Maryland
STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

VOLUME 7 | *August, 1958* | NUMBER 8

TRANSACTIONS

One Hundred Sixtieth Annual Meeting

MEDICAL AND CHIRURGICAL FACULTY
of the State of Maryland

April 16, 17, 18, 1958

The Alcazar, Baltimore Maryland

SCIENTIFIC SESSIONS
Wednesday, Thursday, and Friday, April 16, 17, 18, 1958

BUSINESS SESSIONS
April 16, 18, 1958

ALSO

MEMBERSHIP DIRECTORY

May 31, 1957—May 31, 1958

FOR COMPLETE TRANSACTIONS
See Volume 7, No. 9, September 1958, Maryland State Medical Journal, for completion of 1958 Transactions.

Scientific Paper

PROBLEMS OF PEPTIC ULCER*

SARA M. JORDAN, M.D.†

The problems of peptic ulcer are in this mid-twentieth century still numerous and in some instances subjects of controversy. That will undoubtedly remain the status quo until the question of etiology is completely freed of all obscurity and the revelation by which that enlightenment comes may change all our present concepts of the disease. Working, as we are, more or less with hypotheses to explain the cause of peptic ulcer, we find ourselves dealing with a malady which affects an estimated 4 to 10 per cent of our population at some time in their lives, which is the cause of death in about 4 per cent of those having the disease and which disables many others to a degree that is incompatible with their happiness and with their best efforts in work or play.

Estimates of the incidence of peptic ulcer and even of its mortality in this country are difficult to obtain with any degree of accuracy since they are dependent upon autopsy and life insurance statistics as well as on data from the medical centers of the country. Increased skill in diagnosis has probably been responsible to some degree for marked increase and for detailed variations in recent years but whatever the actual figures are, there is no question as to the importance of the disease in the economic and social life of our nation.

The knowledge of etiology available to us derives from experimentation and clinical observations. Experimentation has shown repeatedly that chemical influences which affect hydrochloric acid secretion or which effect a diversion of that acid from its usual site of action produce, or prevent, the formation of ulcers. Such chemical influences may be direct or indirect and they are attended by changes in motility of the stomach and duodenum, and by vascular changes at the site of the ulcer. These are the experimentally known and observed facts of ulcer formation. Still obscure are the forces which lie behind those changes in the human being. Do 10 per cent of our population have a diathesis to ulcer because in their bodies the pathways from hypothalamus to stomach mucosa or to the acid-secreting glands have an unusual capacity for receiving and transmitting forceful impressions? And if so, why? Will the answer to these problems perhaps be found in the endocrine system?

It is well recognized that blocking of increased acid production has resulted from vagotomy or vagectomy. It has also been recognized clinically that stressful situations of many varieties may result in ulceration of the stomach or duodenum. The Curling ulcer as a sequel to burns and the ulcer described by Cushing as a sequel to neurosurgical surgery are examples of a wide variety of stressful situations including other diseases which appear to produce ulcer. Gray's postulate that such ulcers are the result of an increased acid secretion due to increased circulatory adrenocortical hormones is counterbalanced by the fact that similar corrosive ulcers appear in the adrenalectomized animal. Another postulate in support of adrenal participation in the cause of this disease is that ulcer occurs in the shock phase of the alarm reaction of the stage of exhaustion and is mediated by some unknown

* Harvey Grant Beck Memorial Lecture, presented on April 18, 1958 at the One Hundred Sixtieth Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland.

† Director, Department of Gastroenterology, Lahey Clinic, Boston, Massachusetts.

mechanism. It has also been shown, interestingly enough, that increased acid production resulting from corticoid therapy is not blocked by vagotomy.

Clinical observations, especially in patients known to have a past history of ulcer and observed through recurrences, give us uncontrolled and subjective information on what appear to be precipitating factors. Among these are, not infrequently, indiscretions in diet, resumption of smoking, alcoholic excesses, failure to continue the habit of exercise (all within the control of the patient) and less controllable factors, such as periods of stress and strain in work or family relations, or severe emotional traumata.

To these experimental and clinical data, less illuminating than we would wish, we must cling until there is more light upon the problem of ulcer etiology, and with that light, a clearer insight into the management of this disease.

With this still prevailing confusion and obscurity regarding the exact background of ulcer formation, current problems resolve themselves, practically speaking, into those of diagnosis and treatment. The complexities and frequent frustrations of ulcer treatment make it of paramount importance that peptic ulcer should be diagnosed as early and as accurately as possible: early so that healing can be accomplished before chronicity has resulted in a long period of partial disability and accurately so that there be neither negligence nor unnecessary restrictions.

While the large majority of ulcers make themselves known by an unmistakably typical history, three situations may confuse the history: (1) the ulcer, complicated by partial obstruction or localized penetration, may take on variations in history sometimes quite atypical of the uncomplicated ulcer; (2) other diseases of the digestive tract—such as biliary tract disease, pancreatitis and functional disease of the digestive tract—may so confuse the clinical picture that the ulcer component is missed; (3) silent ulcers are a definite entity and, since they may remain silent only until hemorrhage or perforation occurs, it is of importance to discover them prior to those complications, if that is possible, by routine radiological examinations or by exploration during surgery for other conditions.

In the patient with abdominal complaints, a history of epigastric pain radiating to the back and occurring at night and with the periodicity and relief measures characteristic of ulcer suggests strongly that the ulcer is penetrating the wall of the stomach into an adjacent structure, usually the pancreas. The pain of chronic relapsing pancreatitis may usually be differentiated from that of a penetrating ulcer by its unremitting character and by its failure to be relieved, at least temporarily, by food or alkalies. The pain of gallbladder disease without other digestive tract lesions is familiarly recognized as colicky, often nocturnal and accompanied by vomiting and tending to localize in the right upper quadrant with radiation to an opposite point in the back. But the history of chronic digestive disorders without episodes of colicky pain in the patient with gallstones may be confused with that of ulcer distress, especially if warm food or liquids are used to alleviate it. When both diseases are present, there is confusion until the two kinds of symptoms are differentiated. In my opinion, the chronic digestive disorders of gallbladder disease without colic are usually due to irritability of the colon giving symptoms of such a protean character that they must always be identified and classified either into those from the single entity of the irritable colon alone and those attendant upon peptic ulcer or gallbladder disease. This is especially true in postgastrectomy cases where a new stomal ulcer may be suspected, whereas the actual diagnosis is irritability of the small and large intestines, the result of a poorly functioning gastrojejunostomy or, as is frequently the case, caused by irritability from antacid medication combined with laxatives which have been prescribed on the false diagnosis of stomal ulcer.

The symptom of vomiting, with or without pain and with or without a history of ulcer, may be present in gastric ulcer and is caused by partial obstruction due to either spasm or cicatricial

stricture. The ulcer causing the pyloric obstruction may be located at the pylorus itself or higher in the body of the stomach, in which case the pyloric spasm is a reflex phenomenon. In either case, healing of the ulcer relieves the obstruction unless cicatricial obstruction is unyielding.

These and other pitfalls in the history of a patient may obscure the classical clinical picture of ulcer to a degree where effective treatment is delayed and healing jeopardized, unless a complete examination with radiological help reveals the true picture.

In these days of warnings to the public about the danger of exposure to x-ray, it is sometimes difficult to persuade patients of the necessity for adequate x-ray examination. Since its value is inestimable for gastrointestinal disease, one should have at hand for such persuasion the statistics of the risk of exposure.

In no field of medicine has the x-ray examination been of more value than in the detection of peptic ulcer. Whatever the history may suggest, it is essential that a complete gastrointestinal study be made. Too often a negative result is based on an incomplete examination and later positive findings are a source of jeopardy to the patient and regret to the physician.

One must also look for trouble everywhere in the digestive tract. The esophagus should be examined both with fluoroscopy and film examination as carefully as the stomach and small and large intestines. At this point I might say a few words about the relationship of radiologist to gastroenterologist. If they are not one and the same person, as is the case in many instances, they should, in my opinion, be very closely and cooperatively associated in their study of a patient. Each can help the other to an immeasurable extent and neither can stand alone in his diagnostic efficacy. This is not to affirm that an obvious crater in the duodenal bulb cannot be diagnosed by the radiologist as a duodenal ulcer but most often the diagnosis is not a definitive x-ray possibility and in the interest of the patient it is essential that the clinician who knows the patient collaborate with the radiologist who has the objective evidence of the structure and function of his digestive tract. Finally, cooperation and humility on both sides are indispensable attributes.

The radiologist of today has at his disposal many procedures and devices with which to examine the digestive tract. The clinician has learned much during the past half century from his own experience and from that of other workers. With the collaboration of these two specialists no peptic ulcer of the esophagus, stomach or jejunum should be missed nor should any patient who does not have an ulcer be consigned to an ulcer regimen. Yet errors in both these directions can be made and are made.

In studying the digestive tract radiologically for peptic ulcer, inspection should begin in the esophagus where occasionally the presence of an ulcer in the distal end is missed until stricture has occurred and then it is a regrettable possibility that there might have been healing without stricture if the lesion had been discovered earlier. The cardia and fundus of the stomach should also be examined with the greatest care. Here the very early cancer is unfortunately often missed and small ulcers may also escape detection. The posterior wall of the stomach throughout its entire extent is likewise an area where detection of ulcer is difficult in spite of the great help which palpation and air contrast spot films give us. The pylorus has always been perplexing and remains so. Spasm, with or without ulcer and carcinoma, must be considered and differentiated when there is narrowing there and an ulcer can be definitely diagnosed only if a crater is seen. In the first part of the duodenum the diagnosis of ulcer may be easy and definitive when there is a definite crater and with a consistent deformity of contour without crater there is reasonable assurance that there is or has been an active ulcer with resulting deformity. Fortunately more than 90 per cent of duodenal ulcers occur here in the first part of the duodenum. But when they do

occur in the second part of the duodenum the x-ray diagnosis is not easy. Narrowing of this segment, localized tenderness to palpation and the occasional visualization of a crater are the best clues to the presence of this disease in this critical area, especially when these signs are combined with the exclusion of an ulcer elsewhere in a patient who clinically must have an ulcer. This area is a critical one because of the possibility of common duct involvement if there is extension of inflammation or penetration.

The stomal ulcer after both gastroenterostomy and subtotal gastric resection is also a diagnostic problem both clinically and radiologically. In my experience when the diagnosis is not immediately obvious by the presence of an unmistakable crater at the stoma, in the jejunum or on the gastric side, the best diagnostic criteria are tenderness over the stoma which is usually quite easily palpable; a residual fleck of barium at that site when the gastric remnant and jejunum are otherwise empty of barium; a typical ulcer history and, on abdominal palpation during the physical examination, a localized area of tenderness to the left of the umbilicus. Not all stomal ulcers fulfill all these criteria but fortunately many of them do.

As for other diagnostic measures, there are of course the physical examination and the gastric analysis. From the physical examination, we get help only if there is a localized area of tenderness to palpation in the area slightly to the right of the mid-epigastrium in the presence of an ulcer history. This finding of acute tenderness suggests an acute ulcer, even one with localized penetration. As for chemical tests the gastric analysis continues, in our opinion, to be of value both as a diagnostic aid and as an indicator of progress in healing, this being especially true in the duodenal ulcer. Tests for occult blood in the stools are of value only when conditions of diet are under controlled observation and such other sources of bleeding as gingivitis, polyps or hemorrhoids are eliminated.

Gastroscopy has been a very useful adjunct to diagnosis when the ulcer is in the stomach or at the stoma of an anastomosed stomach. It has its limitations of use because of failure to visualize certain areas of the stomach, but when a gastric ulcer can be visualized, diagnostic differentiation from a malignant lesion is sometimes facilitated and with repeated examinations the progress of healing can be confirmed with direct vision.

Cytological studies have also been of value. When cells positive for malignancy are found, we have no question as to diagnosis since with over 400 cases only one false positive report was made and that was in a case of polyposis where no malignant changes were found on pathological examination and at an earlier stage of this work when our cytologist had had less experience than she has today.

Again I say, we should make no mistakes in finding peptic ulcer but we do. Mistakes are made in both ways—not finding them when they are present and finding them when they are not there. The muddled history and the difficulties of visualizing certain areas of esophagus, stomach, duodenum and jejunum are the chief reasons for not finding them. Too great refinements of x-ray technique are sometimes the reason for finding them when they are not there: in other words with pressure spot films one may mistake a globule of barium in a rugal furrow for an ulcer crater. Repeated examinations to prove consistently visualized deformities and sometimes a trial ulcer management for relief of symptoms not otherwise relieved may make the diagnosis conclusive.

With the diagnosis made, either with ease by simple classical measures or with difficulty requiring extraordinary measures, the problem of treatment must be solved. Fortunately, uncomplicated esophageal, duodenal and stomal ulcers are now generally considered medical problems. With the gastric ulcer, every now and then a wave of controversy occurs both for and against immediate surgery as soon as such an ulcer on the gastric side of the pylorus is discovered. That controversy will be discussed later. The medical treatment of the uncompli-

cated peptic ulcer remains in most hands a tribute to Bertram Sippy whose life was dedicated to the treatment of digestive diseases, especially peptic ulcer and the irritable colon. His published method of treating ulcer, based upon the principles of rest, diet and neutralization enunciated in the last century by Cruveilhier, Fox and Abercrombie, has stood the test of time and experience. It has been modified for the individual patient, as was done also by Sippy, himself. We have run the gamut of substitutes and shortcuts but in our experience no form of treatment equals or excels the bed rest, bland feedings, use of hourly milk or milk and cream and of neutralizing and anticholinergic medication. It is entirely possible that this therapeutic procedure, which requires time and vigilant control, may in the future be discarded for an equally efficient shortcut procedure perhaps directed at the underlying cause of ulcer. At present, however, this method of treating the uncomplicated active ulcer by rest, neutralization of acid and lessening of hypermotility is entirely satisfactory. The nonabsorbable aluminum hydrate products have been substituted for the absorbable powders which Sippy used and with us a small amount of diluted warm orange juice is given with each milk feeding. Very mild sedation and an antispasmodic measure are provided by a mixture of belladonna and phenobarbital. Supplementary vitamins are added to the regimen. If night pain has occurred previous to admission, neutralization is given hourly during the night for a few days. Within a few days, a decision can be reached as to the efficacy of medical treatment for if symptoms persist for more than twenty-four to seventy-two hours under this strict regimen it is unlikely that medical measures will be effective.

The problem of whether or not the patient should be hospitalized is not a problem with us for it is our firm belief that hospital treatment, if it is at all possible, is a real necessity. There are several reasons for this opinion: First, those ulcers healable by medical management must be differentiated from those which are intractable in themselves and, in our judgment, this differentiation can be made only with a trial of a few days hospital management. Secondly, ulcer patients should have instruction on the nature of their disease and counsel as to the necessary changes to be made in their way of life to make permanent the healing of the ulcer. Such counsel can best be given during the period of ulcer healing and under the guidance of their medical advisor. Third, the ulcer heals more rapidly and permanently with hospital management than with unsupervised ambulation. Complete healing at this opportunity may in our experience prevent later complications.

Following hospital treatment it is essential that there be regular appointments for follow-up observations until the strict regimen can be modified under guidance.

Recurrences after medical treatment in the uncomplicated ulcer have been ascribed by patient and physician to several types of digressions from the ulcer life: indiscretions in diet, resumption of smoking, alcoholic excesses, physical or nerve fatigue or tension and emotional traumata. Sometimes in the same patient at one time indiscretions in diet and at another time an emotional trauma seem to be the precipitating factors in recurrence. But permanence of healing is not just an ideal, impossible of attainment: not a few patients report after years (the longest, in my experience, thirty-four years) that there has been no recurrence of symptoms.

Complications of peptic ulcer cause many problems. Obstruction is readily diagnosed and if it is due to cicatricial stenosis or unrelievable inflammatory reaction, surgery is the only effective treatment for it. However, obstruction may be a temporary complication, amenable to treatment. The so-called Wilkinson drainage, a procedure first developed by Dr. S. Allen Wilkinson of our clinic, has proved useful in differentiating these two types of obstruction.

Perforation into the peritoneal cavity is well recognized as a dramatic and usually easily diagnosed condition. With medical treatment by intubation as advocated for certain cases by Mr.

Herman Taylor of England, we have had no experience. Surgery at the earliest possible time is for us still the best treatment. Localized perforation into an adjacent organ, pancreas or left lobe of the liver, is usually suspected by the intensity and radiation of pain and by its intractability. It is the commonest indication for surgical intervention in our treatment of ulcer but here, too, some cases do heal under an intensive medical regimen.

Hemorrhage offers the most serious and frustrating problem. Recurrence of hemorrhage is always an impending hazard, in some cases even after subtotal resection. Cases with a history of a single episode of bleeding seem to have a better prognosis regarding recurrence than those with multiple occurrence of either hematemesis or melena. In cases of hemorrhage after resection, irradiation treatment has been used by us with some success. Medical treatment for hemorrhaging cases is in our hands conservative in all respects. Diagnostic x-ray examination is done only after bleeding has subsided unless there is urgent need for locating the site of the hemorrhage. Oral feedings are not given for two or three days after a massive hemorrhage and the patient is kept under sedation usually with sodium phenobarbital, as needed, for restlessness. One of the most critical decisions in medicine is that of selecting those patients in whom surgical intervention is necessary to stop hemorrhage and save life. Fortunately surgery in these days is a relatively safe procedure even for the elderly patient in a critical condition and many lives are saved by ligation of a sclerotic artery in the base of an ulcer in elderly patients.

A subject about which much is talked and written is the question of surgery for all gastric ulcers. Since gastric cancer is ulcerative in form in an estimated 20 per cent and since only by microscopic examination can it be immediately determined whether or not malignant tissue is present in an ulcer, certain surgeons advocate the resection of all stomachs in which a gastric ulcer is found. Statistics as to the malignant nature of gastric ulcer have been confused by the fact that obviously malignant ulcerating lesions have been classified with lesions which appear benign. If this distinction is made, however, and only those lesions which have the characteristics of a benign ulcer are considered, it will be evident that only about 9 or 10 per cent of such lesions are or will be malignant. Then the healable benign ulcers must be separated from the unhealable ones for, in a terrain as susceptible to cancer as is the stomach, no unhealed lesion must be left in situ. Therefore, in order to treat successfully the harmless and healable gastric ulcers and to save the stomachs in which they occur, certain criteria have been satisfactorily used for many years: that symptoms are completely relieved, that the x-ray deformities completely disappear, and this includes a return of complete flexibility to the wall of the stomach around the ulcer; that occult blood, if present in the stool, disappear; and that there be no recurrence of the ulcer. All these criteria must of course be fulfilled under the vigilant guidance of the physician, in the hospital, and in a reasonable period of time, usually about three weeks. With such a conservative course, it is entirely possible to keep many stomachs intact for many individuals who never have a recurrence of digestive disturbances. In a series of 1000 cases so treated, we missed the malignancy or kept the patient under medical management for more than two months in 2.9 per cent. This study included cases of earlier years of treatment when surgical mortality was higher than this figure. Over the years this policy of trial management for proof of the benign character of a seemingly benign ulcer has paid dividends in the preservation of the intact stomach and the prevention of postoperative morbidity and in some cases the malnutrition which follows subtotal resection. It must be emphasized, however, that the utmost vigilance on the part of the physician and the greatest cooperation on the part of the patient are essential for the success of this policy.

A final problem for the physician treating a patient with peptic ulcer in any location is the question of when surgical intervention is

necessary. Intractability is the word used but it has many variations in meaning. In our experience, the intractable, uncomplicated ulcer is almost always one which has penetrated, usually into the pancreas, and has no base of gastric tissue from which to heal. Such a condition can be determined within a few days of medical treatment and in such a case an operation is the only cure. However, the so-called intractable patient with an otherwise tractable ulcer can often be treated successfully and his intractability transformed by relief of distress and enlightenment on the nature of his disease. Too early surgical intervention in such cases often results in stomal ulcers or morbidity from resection and in either case the physician regrets his failure to persist with medical treatment.

The jejunal or stomal ulcer, which in former years caused great consternation and frustration, can in many instances be treated medically like peptic ulcer in other locations. Re-resection or irradiation is sometimes required, especially in cases complicated by hemorrhage.

The so-called dumping syndrome, an unfortunate sequela of resection, is sometimes a problem for two reasons, the unhappiness of the patient who suffers from nausea, fainting, sweating and dizziness after a normal meal and is usually underweight and under par. The cure is often not easy. The use of easily digestible dry food in five meals daily, fluids taken between meals and general supportive measures is often successful. In our experience this problem can be prevented by a mechanical arrangement of the gastric remnant and jejunum which allows retention of food in that area long enough to function almost like an intact stomach.

In conclusion, I would like to emphasize that while the problems of peptic ulcer are still numerous and often complex, it is of paramount importance to the patient with peptic ulcer that he have an accurate and early diagnosis, intensive medical treatment (when this proves its efficacy in an early stage) and referral for surgical treatment when there is a reasonable question of safety or efficacy of medical measures.

The Lahey Clinic,
Boston, Massachusetts

THE TIME: *Friday, September 12*

THE PLACE: *Ocean City*

THE OCCASION: *Semi-Annual Meeting of Medical and Chirurgical Faculty*

Special Article

MEDICAL SCIENCE: MAN'S TRUE GLORY*

DAVID B. ALLMAN, M.D.†

In the spring a young man's fancy turns to thoughts of love. But it's different with the President of the American Medical Association; he must think of speeches and meetings.

For example, in only eight days my itinerary calls for four meetings, six speeches and several thousand miles of air and rail travel. Then, of course, one must sandwich in a few interviews with newspaper, radio and television reporters.

At times you find yourself asking: "Is the game really worth the candle?"

Perhaps your own Dr. William Welch, who was A.M.A. President in 1910, answered this as well as anyone when he said:

"I know of no nobler work that any member can engage in than to further the interests of the Association."

Those of you who actively participate in the business and projects of the A.M.A., the Chirurgical Faculty and the county societies know the pleasure and the satisfaction that can come from serving your colleagues, patients and communities.

Fortunately, we in medicine have had a loyal group of executive secretaries and personnel to aid us in all of our endeavors.

Here in Maryland, you have been fortunate in having had the grand services of Mr. Walter Kirkman for many years.

Now you have acquired the talents of Mr. Jack Sargeant, former executive secretary of the Broome County (New York) Medical Society.

As President of the A.M.A., I hear many reports about the work of executive secretaries, and I want to tell you—the doctors of Maryland—that all the things I've heard about Jack Sargeant have been good—in fact, they've been excellent.

Here's the kind of tribute the Broome County President paid to him:

"There were no precedents to follow, no definite pathway to guide him. It was a challenge to his ingenuity. He quickly grasped our ideals and ideas of service to patients, to the members of our society and to the community.

"Jack made friends easily. He came to us without any prejudices and refused to develop any. His chief aim was to be of service, but he was careful to always stay in the background serving and pushing the society's officers to the foreground."

I congratulate the committee on its wise choice, and I want to wish Mr. Sargeant good luck and all the success possible.

Medicine is Cosmopolitan

Here in Maryland and Baltimore, Jack, you will find a rich medical heritage—undoubtedly one of the richest in the nation. For example, it was here in Baltimore 110 years ago that the American Medical Association held its first annual meeting.

It was Maryland that provided three illustrious A.M.A. Presidents—Doctors William Welch, William Thayer and Dean Lewis. And, of course, it was Maryland that gave American medicine the revered Sir William Osler.

Despite all the significant medical contributions from Maryland—past and present—medi-

* Delivered on April 17, 1958 during the One Hundred Sixtieth Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, Baltimore 1, Maryland.

† President, American Medical Association.

cine here is generally the same as in New York, the midwest, the west coast, or any part of the world.

We know that *medicine* and *good medical work* do not belong solely to one State, one region or even one particular country. They are cosmopolitan—they belong to all the world and are at home in any country.

Language, race, money and even government are not insurmountable barriers to medicine and medical doctors.

Medicine itself is a universal language because its procedures—new and old—generally can be equally valuable on every continent.

Medicine is a worldwide profession of mercy, comforting the sick and injured regardless of nationality, creed or color.

Medicine is not a self-seeking profession because the medical benefits to mankind come first before cost and recompense. And even though money sometimes is required to provide facilities, equipment and supplies, unbelievable medical accomplishments have been carried out in many of the most poverty-stricken areas of the world.

Yes, even in communistic and socialistic States medical men strive to benefit the patient despite government intervention, red tape and all the evils of state medicine. Even a government-directed doctor seeks to improve health and relieve sickness through medical science, and to ease fear through his art of medicine.

So, I am firmly convinced that medical science is man's true glory. Through its full use, we can do more for man's true happiness and peace, than can all the gifts and loans of money, and all the demonstrations of military might.

I believe this because medical doctors are men of conscience, seeking to do the right thing in a way that is just for all human beings. Doctors detest evil and fear; they hate war and its resultant suffering. They love humanity and they have a driving, conscientious obligation to all men, whether it is in medical care, in community activities, in political endeavors, or in the promotion of moral conduct.

Here in the United States, and I am sure it is true elsewhere too, medicine repeatedly has demonstrated to the public its intense integrity and its complete feeling of responsibility for the best medical care for all.

Third-Party Intervention

It is a curious fact, however, that despite medicine's achievements, high intentions and good character, the profession constantly is being invaded, or encroached upon, by various third parties.

I recall a few lines from Dr. Roger I. Lee's book, "The Happy Life of a Doctor," of a few years ago:

"At this moment," he wrote, "one must be both blind and deaf not to see and hear the efforts made by certain of the laity to control and direct the destinies of the medical profession. The doctors seem content, too content perhaps, to permit what we in the medical profession call the extroverted professions, extroverted individuals and politicians to guide their destinies."

I hope no one here tonight is either blind or deaf to the threats of third-party intervention in the field of medicine and medical practice.

The *threats* are *real*. The *dangers* are *real*. To be alive and alert *tomorrow* to the outsiders' schemes may be too late.

Let's reaffirm our complete faith in the private practice of medicine. Let's warn America again that any system of medical care that uses a third party to bring doctor and patient together cannot, and will not, equal our standards of care, and that any party coming between the doctor and patient, immediately or ultimately, will lead to deterioration of medical care.

It is disturbing to me, as it must be to you, that we are forced to defend America's long-tried medical system that has brought our nation the highest standards of medical care the world has ever known. The fruits of our kind of medical service are clearly apparent in our nation, and yet there are corporate entities that directly or indirectly seek to change or scrap the present medical system.

Take fees, for example. How many times in recent years has medicine had to thwart efforts by outsiders to write fee schedules for us?

It is my belief that if doctors in a county or a State wish to establish a fee schedule, that is their business. To me no group is more capable of developing satisfactory fee schedules than doctors, themselves.

I further believe that all of us must be alert to those eager schemers in government, in the insurance industry, or in labor and management who would like to establish our fees for us. Because fees are that aspect of medicine coming under the most criticism by patients, we cannot afford to be disinterested in the problem. We cannot afford to be apathetic or lackadaisical about third-party interference in this area. If we are, we may awake some day to find the "outsiders" have done a job for us. And I'm willing to wager that *none of us* are going to like the job they have done.

Government in Medicine

It also is my belief that the medical profession with its system of private practice should be steadfastly upholding the ideals of a free, competitive society even though we are living in an era that too often de-emphasizes—or relegates—personal responsibility to someone else. Actually, I think we conscientiously *have* tried to promote the ideals of freedom, personal initiative and responsibility, and self-reliance. As a result, physicians for the most part still are answerable to the people. Nevertheless, there has been encroachment into the private practice of medicine, and there are large, third-party sponsors of medical service. The largest, without a doubt, is government at all levels, but primarily at the national level.

Because government intrusion into medical services has been labeled "beneficent," there has been wide acceptance by legislators and the public of government's role in medical and health affairs. Unfortunately, some legislators propose health measures to please pressure groups and to gain votes. Apparently, little interest is shown by these lawmakers for the preservation of individual freedoms, a sound economy or good medicine. This may be good politics, but it leads to bad medicine.

Nevertheless, segment after segment of the American population is coming under federal health schemes. Last year a large number of private practitioners, for the first time, confronted many thousands of men and women in a doctor-patient relationship arranged by Uncle Sam via the Medicare plan.

One of the older federal programs that has shown steady development is the Veterans Administration. Since 1917, when the first purely medical benefits for veterans were authorized or limited to veterans with service-connected disabilities, the V.A. has grown immensely and has accumulated great power. With one-eighth of the population eligible for V.A. care—all they have to do is apply and claim that they are unable to pay—the threat to private practice is apparent.

The United States' obligation to its disabled veterans should be met, of course, but the question constantly arises: "It is fair for millions of veterans who have suffered no disabilities as a result of their military service to receive free medical care and hospitalization at the expense of the rest of the population?"

Less than two years ago the Social Security Act also was amended to permit the permanently and totally disabled person 50 years of age or older to draw Social Security benefits which they would otherwise not have been eligible to receive until they were 65—or in the case of women—sixty-two.

Now the proposed Forand Bill would place the health care of the aged and other OASI claimants under government supervision. It would provide government hospital and medical care for about thirteen million Social Security claimants by amending the Social Security Act.

In my House of Delegates address in Philadelphia last December I explained why Medicine is opposed to the Forand Bill. If medicine is to keep government from advancing another giant

step toward complete socialization of medicine, every physician must be fully informed and prepared to oppose this Bill.

If we are not, we may have to ask ourselves this year, or in 1959: "Where was I and what was I doing when my fellow Americans and my profession lost their freedom?"

Government, of course, has some responsibility for the health of its citizens, but in general, government programs should be limited to those which cannot be carried out by private resources.

I believe good health is something we *acquire* by our own efforts. It is not a right that is guaranteed by government. All we should expect as free citizens is the right of an equal opportunity of access to the means of good health. Then it is up to us as responsible individuals to acquire good health by our own efforts—just as we find shelter, food and clothing.

There are legitimate areas of government concern, of course—the indigent and mentally ill, should be cared for. But even for these, local financing should take precedence, with the federal government entering only when absolutely necessary. The government's purpose should be to stimulate the development of private resources and to promote a climate in which private effort and ingenuity can exert their full effects. If our government does not follow this course, then we cannot and will not have a democratic and free enterprise system. Instead, we will have a cradle-to-the-grave government that guarantees us all the essentials of existence, including food, shelter, clothing, medical and dental care, and perhaps even an automobile!

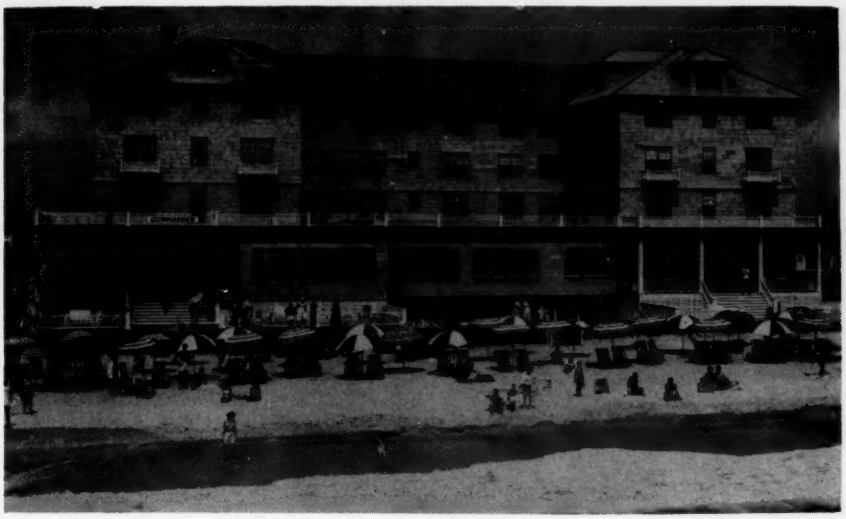
The Tiny Banyan Seed

I am afraid that I have wandered astray from my original subject, but I am sure you will agree that the matter of third-party intervention into medical care is a serious, continuing threat. This whole idea of subordinating individual freedom and initiative to government authority and regulation reminds me of the fable of the tiny banyan seed that landed atop a palm tree and exclaimed: "I'm weary of being tossed around by the wind. Let me stay for awhile among your leaves." "Surely," the palm tree replied, "stay as long as you wish."

As the days went by, the palm tree forgot the little seed. But the seed wasn't idle. It sent out little fibers and tiny roots. They crept around the trunk and under the bark and into the heart of the large tree. Realizing this too late, the tree cried out in alarm: "What is this?" The banyan replied: "It's only the little seed you allowed to rest upon you." "But you will have to leave me now," said the palm tree. "You have grown too large and strong." "I can't leave you now. We've grown together. I'll kill you if I tear myself away." Refusing defeat, the majestic palm tree bowed its head and tried to shake the banyan off, but it could not. So, little by little, the tree's trunk shriveled, and only the banyan could be seen.

Ladies and gentlemen, in all history there is no exception to the rule that, whenever the tiniest seed of welfare statism has been allowed to flourish, a creeping—but inevitable—socialistic State is the result.

MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND
PROGRAM OF THE SEMIANNUAL MEETING
Friday, September 12, 1958



Headquarters

COMMANDER HOTEL, THE BOARDWALK AND 14th STREET
OCEAN CITY, MARYLAND

REGISTRATION—9:00 A.M.
Lobby

All members and their guests are urged to register so that an accurate record may be kept of the attendance.

Those who arrive on Thursday, September 11th may register that evening from 7:30 P.M. to 9:30 P.M.

BUSINESS SESSIONS
Beach Lounge, Ground Floor

Component Society Secretaries' Meeting, Thurs., Sept. 11th, 4:00 P.M.
Council Meeting—Thursday, September 11th, 8:00 P.M.
House of Delegates—Friday, September 12th, 9:30 A.M.

All members are invited to attend the meeting of the House of Delegates, but the privileges of the floor are for delegates only.

SCIENTIFIC SESSION—12:30 P.M.
Beach Lounge, Ground Floor

1. Words of Welcome. J. Sheldon Eastland, M.D., President, Medical and Chirurgical Faculty.
2. Recognition and Significance of Anemia. (Illustrated.) C. Lockard Conley, M.D., Professor of Medicine, The Johns Hopkins University School of Medicine, Baltimore.

CLAM BAKE LUNCHEON—2:30 P.M.

On the beach in front of Commander Hotel

DANCE—9:30 P.M. to 1:00 A.M.

Dining Room, Main Floor
Hors d'oeuvres will be served.
(Dress Optional)
Host—The Medical and Chirurgical Faculty

(*over*)

MEDICAL AND CHIRURGICAL FACULTY SEMIANNUAL MEETING PROGRAM

(continued)

WOMAN'S AUXILIARY TO THE MEDICAL AND CHIRURGICAL FACULTY

Mrs. E. Roderick Shipley, President

Social Room, Main Floor

Friday, September 12, 1958

10:00 A.M. Open Board Meeting
Social Hour to follow

The wives of all doctors present for the Semiannual Meeting are invited to attend this meeting. Coffee and buns will be served informally. Come and join us.

The Constitution and By-Laws of the Auxiliary do not provide for a regular Semiannual Meeting. It was the thought of the Officers of the Auxiliary that this would afford an opportunity to be together for an informal discussion of Auxiliary matters.

ARRANGEMENTS COMMITTEE

Committee on Scientific Work and Arrangements of the Medical and Chirurgical Faculty: NORMAN R. FREEMAN, JR., M.D., *Chairman;* NATHAN E. NEEDLE, M.D.; WILLIAM E. GROSE, M.D.; HOUSTON S. EVERETT, M.D.; EVERETT S. DIGGS, M.D.

NOTES

HOTEL RESERVATIONS: It is suggested that if you have not made your reservation that you do so immediately by writing to Mr. JOHN B. LYNCH, PROPRIETOR, COMMANDER HOTEL, OCEAN CITY, MARYLAND. All reservations for rooms are to be taken care of by members writing *DIRECT* to the hotel. The Beach Plaza and Harrison Hall are the hotels cooperating with the Commander Hotel.

CLAM BAKE LUNCHEON: The menu will include tomato juice, Eastern Shore clam chowder, raw clams on half shell, steamed clams from the pit, lobsters from the pit, Maryland fried chicken, deviled crabs, steamed crabs, corn on the cob from the pit, iced watermelon, and iced tea. *Cover charge*, including tip, is $3.75 per person. Checks should be made payable to the Medical and Chirurgical Faculty and should be mailed to 1211 Cathedral Street, Baltimore 1, not later than FRIDAY, SEPTEMBER 5, 1958, sooner if possible. Upon receipt of check, tickets will be mailed promptly.

DANCE: This is an attractive climax to the Semiannual Meeting and the members are urged to remain for this occasion, for which there is no charge. There are no provisions made at the Commander Hotel for the licensed sale of alcoholic beverages.

PARKING FACILITIES: Ample free parking space in close proximity to the Commander Hotel.

FISHING: Boats available for fishing.

ROUTES TO OCEAN CITY

(Courtesy of the Automobile Club of Maryland)

FROM BALTIMORE: Driving around via ELKTON—U.S. 40 to GLASGOW, DEL., turn right on #896 into #71, continue into U.S. 13, bypass DOVER, into U.S. 113, into Maryland turning left on U.S. 50 to OCEAN CITY. 160 miles.
VIA CHESAPEAKE BAY BRIDGE—Follow #2 to U.S. 50, left to Bay Bridge, continue on U.S. 50 through WYE MILLS, bypassing EASTON to CAMBRIDGE and SALISBURY to OCEAN CITY, 140 miles.

(Alternate): As above to Bay Bridge; follow U.S. 50 to junction with #404, left into Delaware #18 to GEORGETOWN, right on U.S. 113 to U.S. 50 to OCEAN CITY. 127 miles.

FROM SOUTHERN MARYLAND: Vicinity of LEONARDTOWN—Follow #5 into U.S. 301, to U.S. 50, right to Bay Bridge, cross and continue with U.S. 50 via CAMBRIDGE and SALISBURY to OCEAN CITY. 188 miles.

(Alternate): As above to Bay Bridge, follow U.S. 50 to junction with #404, into #18, to GEORGETOWN, right on U.S. 113 to U.S. 50 to OCEAN CITY. 175 miles.

FROM EASTERN SHORE: Lower Shore—From EASTON, through CAMBRIDGE, SALISBURY to OCEAN CITY, via U.S. 50. 78 miles.

Northern Shore: Either U.S. 213 or #313, south to #404; east to #18 to U.S. 113, right into U.S. 50, left to OCEAN CITY. 78 miles from WYE MILLS, 64 miles from DENTON.

FROM WESTERN MARYLAND: CUMBERLAND—U.S. 40 to HAGERSTOWN and FREDERICK to Edmondson Avenue Extension, follow east-bound arrows into Franklin Street to Mulberry Street, to St. Paul Street; turn right to Hill Street; right two blocks to Hanover Street; left across Patapsco River Bridge into Potee Street, follow #2 to U.S. 50; left across Chesapeake Bay Bridge, follow U.S. 50 to OCEAN CITY, 276 miles from CUMBERLAND, 210 miles from HAGERSTOWN, 185 miles from FREDERICK.

(Alternate): As above to Edmondson Avenue Extension, turning right on Hilton Street, left jog into Caton Avenue, #167 via Hammonds Ferry Road, on to GLEN BURNIE, into #2 to U.S. 50; left across Bay Bridge and continue as above, via U.S. 50 to OCEAN CITY. Mileage same as above.

(Alternate): on Eastern Shore: From Bay Bridge, follow U.S. 50 into #404, into #18 to GEORGETOWN, right on U.S. 113, into Maryland, left on U.S. 50 to OCEAN CITY. 13 miles less than via U.S. 50 through SALISBURY.

Toll on Chesapeake Bay Bridge—$1.25 one way for passenger cars, including driver.

Have You Made Your Hotel Reservation for The Semiannual Meeting of the Medical and Chirurgical Faculty Ocean City, Maryland—September 12, 1958

If you do not have a hotel reservation in Ocean City for the Semiannual Meeting of the Medical and Chirurgical Faculty, Friday, September 12, 1958, please fill out and mail the form at bottom of page, and send it directly to the Commander Hotel. If the Commander Hotel is filled, your reservation will be turned over to one of the cooperating hotels.

Norman R. Freeman, Jr., M.D., Chairman
Committee on Scientific Work and Arrangements

MODIFIED AMERICAN PLAN

Includes Complete Breakfast and Full Course Dinner Each Day

DAILY RATES PER PERSON DOUBLE OCCUPANCY

	Sept. 8–Oct. 3
* Corner Ocean Front Room, tub and shower bath	$11.50
* Ocean or Bay View Room, tub and shower bath	10.50
* Bay View Room, tub or shower	9.50
* Bay View Room and adjoining (small) Single Room, tub and shower (3 person occupancy)	9.00
* Suite, 2 Communicating Rooms, 2 baths, tub and shower (4 person occupancy)	10.50
Family Room, 2 double beds, tub and shower bath. Special for four person occupancy, any age, per person	7.25
Double Bed, Ocean Front, wash stand and toilet	8.50
Double Bed, Bay View, wash stand and toilet	8.00
Single Room, Ocean Front, shower bath	12.00
Single Room, Ocean Front, wash stand and toilet	11.00
Single Room, Bay View, wash stand and toilet	10.00

Children's rates: Children to 6 years old, occupying same room with parents $5.00 per day, 6 to 12 years $6.00 per day, over 12 years $7.00 per day.

For the first 2 persons sharing a double room, the regular double rate will apply even though one occupant may be a child.

* Twin beds.

RESERVATION REQUEST

Commander Hotel

on the Ocean OCEAN CITY, MARYLAND

Name .....

Address .....

City ..... *State* .....

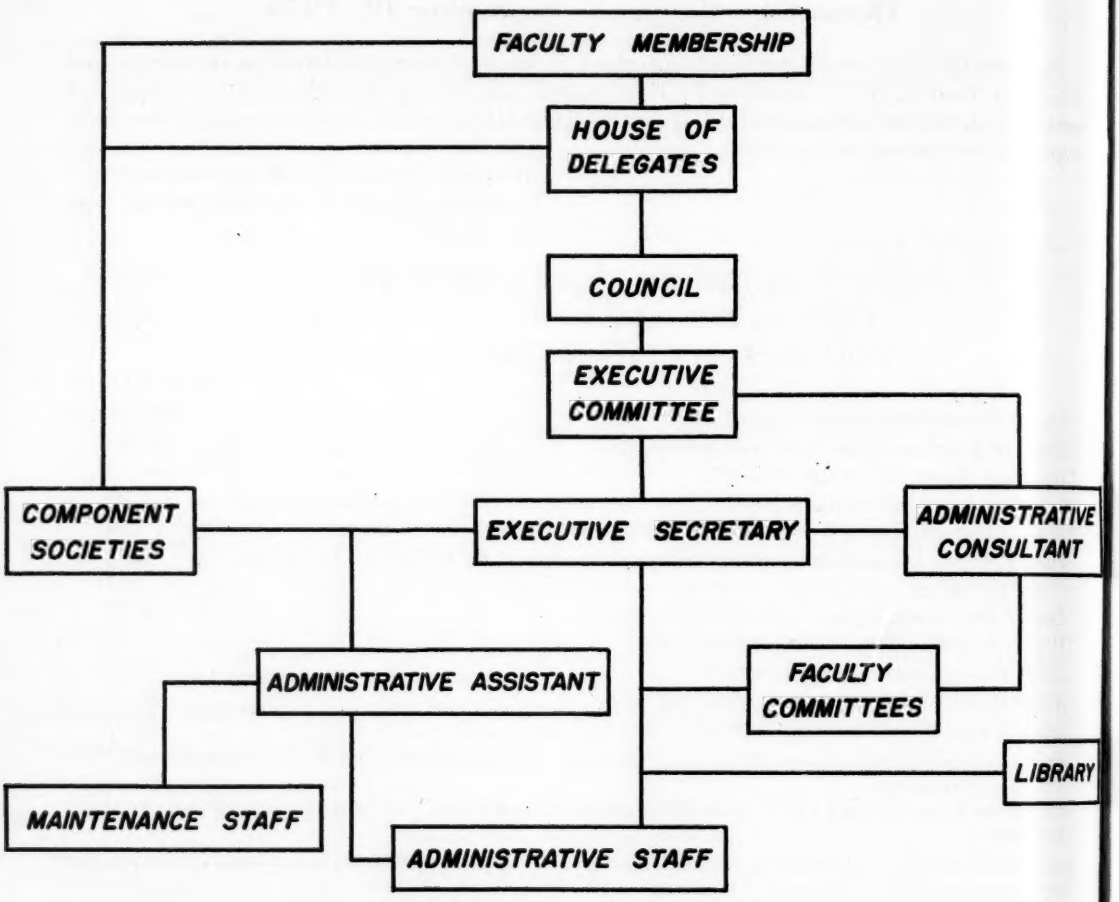
Please reserve ..... *Room* *Rate* .....

Alternate Choice .....

Date of Arrival ..... *Date of Departure* .....

No. of Persons .....

All Requests Subject to Confirmation



ORGANIZATIONAL CHART
MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND
JULY 1, 1958

ARTICLES OF INTEREST

HOW THE MEDICAL AND CHIRURGICAL FACULTY OPERATES

The Medical and Chirurgical Faculty of the State of Maryland was incorporated under a Special Act of the State Legislature passed in 1792. The Faculty is a non-profit organization and tax-exempt. It is composed of 23 component medical societies.

Day to day operations of the Faculty office are vested in the Executive Secretary and Staff who operate directly under the elected officers of the Faculty.

These officers—a President, President-Elect, a Treasurer and a Secretary—are elected at the Annual Meeting of the Faculty by the members of its House of Delegates. Councillors are also elected from various parts of the State. All of the voting for these offices is vested in the House of Delegates, which is the governing body of the Faculty. Members of the House of Delegates are elected by the component medical societies. So by this manner of voting, the *individual members* of the medical societies actually control who is elected.

Between the Annual and Semiannual meetings, authority to conduct the various affairs of the Faculty is vested in the Council. The Council, in turn, elects its own Chairman and Vice-chairman. These two plus the officers of the Faculty constitute an Executive Committee. Special meetings of the House of Delegates may be called at any time.

The Executive Committee can make routine decisions and offer solutions or suggestions for the settlement of the many problems brought before it. It reports periodically and is responsible to the Council for its actions. All action taken by the Executive Committee must be ratified by the Council. The Executive Committee refers matters to the Council for decision. These include, in particular, matters which concern Faculty policy. Such items are considered to be outside of the scope of the Executive Committee's authority.

In the chart opposite this article can be seen the operational control of the Faculty itself.

Questions from component societies, health organizations and the public are answered by the Administrative Staff, if possible.

Policy matters are referred to the Executive Committee for decision and, in turn, to the Council. In some instances such matters are referred to the House of Delegates which, then, can refer them to the individual component societies if the situation warrants.

The Executive Secretary is responsible directly to the Executive Committee. The Staff, in turn, is responsible to the proper controlling members of the administrative department.

Committee chairmen are named, in some instances, by the President and/or Council; in other cases they are elected to their offices by the House of Delegates. All Committee action, except on routine matters, must be approved by the Council.

YOUR MEDICAL FACULTY AT WORK

The Council of the Medical and Chirurgical Faculty met at the Faculty Building on June 10, 1958, and took the following action:

1. Approved action of the Executive Committee in establishing a principle that residents on house staffs, licensed in Maryland, be not permitted to register and take calls referred from the Emergency Medical Call System. Ordered the Hospital Council, Inc., to be so informed for information purposes. The purpose of establishing this principle is to prevent the Resident or members of the House Staff from becoming involved in handling private patients when they should be available at the hospital to perform their regular duties. It is not an easy thing to draw a line as to when and where the handling of these emergency calls would stop.
2. Approved the request of the Department of Health, Education and Welfare to conduct a cytology research study of all female employees of the Baltimore Office of the Department of Health, Education and Welfare. Such a study was approved by the Maryland Society of Pathologists and the Obstetrical and Gynecological Society of Maryland. The study would continue a little beyond two years in order that three smears might be obtained from the same individual at three intervals of one year each. All employees would participate without compulsion on a volunteer basis.
3. Heard the results of the recent state-wide poll on Social Security, complete information on which is available elsewhere in this issue of the Journal.
4. Authorized consolidation of the following two committees:

   Committee Regarding Union Sponsored Clinic for the Employees of the Glenn L. Martin Company

   Joint Committee to Consult with Labor Leaders of Maryland

   the new committee to be known as:

   Joint Committee to Consult with Labor Leaders and Unions in Maryland
5. Authorized publication of abstracts of Council minutes, as well as a Newsletter from the Executive Secretary, both in the Journal.
6. Reactivated the Committee on Asian Influenza for possible preparatory work in the event this matter becomes active again this fall.
7. Approved solicitation of non-A.M.A. members by the President, urging them to join the A.M.A.
8. Approved the principle that members of the Medical Board for Occupational Diseases be permitted to appear and testify regarding private patients before the Accident Commission or any other governmental board, except the Medical Board for Occupational Diseases. The Chairman of the Workmen's Compensation Commission to be so notified, as well as the Deans of Medical Schools in Maryland.
9. Approved the adoption, with minor changes, in the Blood Banks Assurance Program offered through the Baltimore City Medical Society. The program to cover only Baltimore County, Baltimore City and Howard County, with approval being obtained from local medical societies as well. The Blood Banks Assurance program, as it is to be established on a group basis, would provide for assurance of blood when needed by those covered under the program on the basis of two pints for three. The assurance would have to be renewed at the end of each year by additional donations of blood from the assured. It would not interfere in any way with the present blood programs operated by the individual hospitals. The program is to be expanded if and when the situation so warrants.
10. Disapproved the inclusion of chiropodists under Blue Shield, which group of practitioners had requested approval of its inclusion from the Medical and Chirurgical Faculty.

SOCIAL SECURITY POLL RESULTS ANNOUNCED

As mandated by the House of Delegates at the April 1958 Annual Meeting, the Medical and Chirurgical Faculty of the State of Maryland conducted a poll to ascertain the wishes of the physicians of Maryland for inclusion under the Social Security Law.

The President appointed a committee, chairmanned by Dr. Karl F. Mech, to prepare a questionnaire as well as a short summary of the benefits and disadvantages of inclusion under the law. Members of the committee were Drs. Charles R. Goldsborough and Jacob C. Handelsman.

MEDICAL AND CHIRURGICAL FACULTY

Tabulation of Replies to Questionnaire Regarding Social Security as of June 12, 1958

	QUESTION #1 Are you in favor of COMPULSORY coverage under the provisions of the Social Security Law?			QUESTION #2 Are you in favor of VOLUNTARY coverage for yourself under the provisions of the Social Security Law if this can be accomplished?		QUESTION #3 If the answer to 1 or 2 is "yes", would you still vote "yes" if this coverage were tied to other changes or extension of benefits under the Social Security Law such as Govt. paid medical care?	
	Yes	No	No Reply	Yes	No	Yes	No
City	296	543	141	501	369	125	444
County	121	368	80	296	234	68	243
Total	417	911	221	797	603	193	687

TOTAL REPLIES to date—1,556
City—983 and County—573
(2,999 cards mailed)

7 cards received with comments only.

It's Time to Plan Now!!

for

Friday, September 12, 1958

SEMI-ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY

OCEAN CITY

Board of Medical Examiners

MEDICAL LICENSURE DATA OF THE STATE OF MARYLAND FOR GRADUATES OF FOREIGN MEDICAL SCHOOLS

All graduates of foreign medical schools may be accepted after completion of three years training in approved American hospitals, one year of which must be a rotating internship or one year of residency in internal medicine; and, also, one of the three years must be served in an approved hospital in the State of Maryland, if their credentials have been approved and they have presented at least two letters from medical authorities in the hospitals recommending them as to their professional ability and moral character.

Graduates of foreign medical schools are *not* accepted for licensure on the basis of reciprocity or endorsement in the State of Maryland.

A Certificate of Naturalization or formal Declaration of Intention for Citizenship is required. Ability to write and speak English clearly is a primary requisite.

A passing grade of 75 per cent in each subject is required of all candidates.

Effective January 1, 1959, all graduates of foreign medical schools must first take and pass the screening Board Examination given by the Educational Council for Foreign Medical Graduates before being eligible to take the Maryland State Board Examination.

DIRECTORY*

MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

May 31, 1957–May 31, 1958

LIST OF PRESIDENTS—1799–1958

1799–1801—Upton Scott.
1801–1815—Philip Thomas.
1815–1820—Ennals Martin.
1820–1826—Robert Moore.
1826–1836—Robert Goldsborough.
1836–1841—Maxwell McDowell.
1841–1848—Joel Hopkins.
1848–1849—Richard Sprigg Steuart.
1849–1850—Peregrine Wroth.
1850–1851—Richard Sprigg Steuart.
1851–1852—William W. Handy.
1852–1853—Michael S. Baer.
1853–1854—John L. Yeates.
1854–1855—John Fonerden.
1855–1856—Jacob S. Baer.
1856–1857—Christopher C. Cox.
1857–1858—Joshua I. Cohen.
1858–1859—Joel Hopkins.
1859–1870—Geo. C. M. Roberts.
1870—John R. W. Dunbar.
1870–1872—Nathan R. Smith.
1872–1873—P. C. Williams.
1873–1874—Charles H. Ohr.
1874–1875—Henry M. Wilson.
1875–1876—John F. Monmonier.
1876–1877—Christopher Johnston.
1877–1878—Abram B. Arnold.
1878–1879—Samuel P. Smith.
1879–1880—Samuel C. Chew.
1880–1881—H. P. C. Wilson.
1881–1882—Frank Donaldson.
1882–1883—William M. Kemp.
1883–1884—Richard McSherry.
1884–1885—Thomas S. Latimer.
1885–1886—John R. Quinan.
1886–1887—George W. Miltenberger.
1887–1888—I. Edmondson Atkinson.
1888–1889—John Morris.
1889–1890—Aaron Friedenwald.
1890–1891—Thomas A. Ashby.
1891–1892—William H. Welch.
1892–1893—L. McLane Tiffany.
1893–1894—George H. Rohé.
1894–1895—Robert W. Johnson.
1895—J. Edwin Michael.
1895–1896—Charles G. Hill.
1896–1897—William Osler.
1897–1898—Charles M. Ellis.
1898–1899—Samuel C. Chew.
1899–1900—Clotworthy Birnie.
1900–1901—Samuel Theobald.
1901–1902—J. McPherson Scott.
1902–1903—William T. Howard.
1903–1904—Eugene F. Cordell.
1904–1905—Edward N. Brush.
1905–1906—Samuel T. Earle, Jr.
1906–1907—Hiram Woods.
1907–1908—Charles O'Donovan.
1908–1909—Brice W. Goldsborough.
1909–1910—G. Milton Linthicum.
1910–1911—Franklin B. Smith.
1912—Hugh M. Young.
1913—Archibald C. Harrison.
1914—Randolph Winslow.
1915—J. W. Humrichouse.
1916—J. Whitridge Williams.
1917—Guy Steele.
1918—William S. Halsted.
1919—John Ruhräh.
1920—James E. Deets.
1921—William S. Gardner.
1922—Arthur H. Hawkins.
1923—Herbert Harlan (Jan.–Aug.). Harry Friedenwald (Aug.–Dec.).
1924—Philip Briscoe.
1925—Lewellys F. Barker.
1926—Thomas B. Johnson, Deceased December 25, 1925.
1926—Josiah S. Bowen.
1927—Thomas S. Cullen.
1928—Peregrine Wroth, Jr.
1929—Alexius McGlannan.
1930—Henry M. Fitzhugh.
1931—J. M. H. Rowland.
1932—Eldridge E. Wolff.
1933—J. Albert Chatard.
1934—George O. Sharrett.
1935—J. M. T. Finney, Sr.
1936—Frederick D. Chappelear.
1937—Arthur M. Shipley.
1938—Frank B. Hines.
1939—Dean Lewis: Acting President, Victor F. Cullen.
1940—Edward P. Thomas.
1941—Harvey B. Stone.
1942—R. Lee Hall.
1943—Charles R. Austrian.
1944—Jacob W. Bird.
1945—Carroll Lockard.
1946—Thomas R. Chambers.
1947—William T. Hammond.
1948—Charles W. Maxson.
1949—W. Houston Toulson.
1950—A. Austin Pearre.
1951—Walter Dent Wise.
1952—Alan M. Chesney.
1953—Maurice C. Pincoffs.
1954—Bender B. Kneisley.
1955—George H. Yeager.
1956—William H. F. Warthen.
1957—C. Reid Edwards.
1958—J. Sheldon Eastland.

LIST OF VICE-PRESIDENTS

1799–1848—(Unknown.)
1848–1849—John Readel, Jacob Baer, P. Wroth.
1850–1851—Joel Hopkins, P. Wroth, Jacob Fisher.
1851–1853—(Unknown.)
1853–1854—John Fonerden, Albert Ritchie, P. Wroth.
1854–1855—Geo. C. M. Roberts, Samuel P. Smith, Joel Hopkins.
1855–1856—George C. M. Roberts, G. W. Miltenberger, M. Diffenderffer.
1856–1857—P. Wroth, Wm. H. Davis, Samuel Smith.
1857–1858—William Waters, Frederick Dorsey, Joel Hopkins.
1858–1859—Samuel Chew, Stephen N. C. White, Samuel K. Handy.
1859—1863—John R. W. Dunbar, Samuel Chew, Wm. M. Kemp.
1863–1871—John R. W. Dunbar, Wm. M. Kemp, John C. Hopkins.

* Transactions, 1958.

1871–1872—C. H. Ohr, Edward Warren, Richard McSherry.
1872–1873—(Unknown).
1873–1874—Samuel Chew, H. M. Wilson, A. B. Arnold.
1874–1875—Francis T. Miles, James A. Steuart, D. A. O'Donnell.
1875–1876—Christopher Johnston, A. B. Arnold, J. C. Thomas.
1876–1877—P. C. Williams, James A. Steuart, Francis T. Miles.
1877–1878—S. C. Chew, F. E. Chatard, Charles H. Jones.
1878–1879—James C. Thomas, L. McLane Tiffany.
1879–1880—H. P. C. Wilson, James A. Steuart.
1880–1881—L. McLane Tiffany, G. Ellis Porter.
1881–1882—A. H. Bayly, I. E. Atkinson.
1882–1883—Thomas S. Latimer, Richard McSherry.
1883–1884—W. Stump Forward, J. S. Lynch.
1884–1885—John R. Quinan, I. E. Atkinson.
1885–1886—E. C. Baldwin, J. E. Michael.
1886–1887—Thomas Opie, Richard Gundry.
1887–1888—Charles H. Jones, James Carey Thomas.
1888–1889—J. E. Michael, Thomas P. Evans.
1889–1890—T. A. Ashby, C. G. W. Macgill.
1890–1891—Geo. H. Rohé, J. McPherson Scott.
1891–1892—J. W. Humrichouse, David Streett.
1892–1893—J. W. Downey, J. W. Chambers.
1893–1894—John D. Blake, John S. Fulton.
1894–1895—Charles H. Jones, W. M. Nihiser.
1895–1896—Charles G. Hill, Clotworthy Birnie.
1896–1897—Wilmer Brinton, Randolph Winslow.
1897–1898—W. F. A. Kemp, George J. Preston.
1898–1899—Mary Sherwood, J. McPherson Scott.
1899–1900—Samuel Theobald, David Streett.
1900–1901—Samuel T. Earle, Jr., J. B. R. Purnell.
1901–1902—Harry Friedenwald, B. W. Goldsborough.
1902–1903—Samuel T. Earle, Jr., Wilmer Brinton.
1903–1904—Franklin B. Smith, James M. Craighill.
1904–1905—Samuel T. Earle, Jr., D. C. R. Miller, Julius A. Johnson.
1905–1906—Charles O'Donovan, Thomas M. Chaney, Joseph B. Seth.
1906–1907—William T. Watson, Philip Briscoe, William F. Hines.
1907–1908—Roger Brooke, Henry L. P. Naylor, George Dobbin.
1908–1909—Philip Briscoe, William L. Smith, G. Milton Linthicum.
1909–1910—Philip Briscoe, A. P. Herring, Compton Riely.
1910–1911—J. Staige Davis, H. B. Gantt, Timothy Griffith.
1912—J. L. Riley, D. E. Stone, J. A. Chatard.
1913—J. Staige Davis, C. F. Davison, E. B. Claybrook.
1914—C. R. Winterson, A. L. Franklin, Gordon Wilson.
1915—A. McGlannan, J. E. Deets, R. Lee Hall.
1916—L. C. Carrico, M. D. Norris, J. A. Chatard.
1917—D. E. Stone, A. H. Hawkins, J. M. H. Rowland.
1918—Julius Friedenwald, J. E. Deets, J. McF. Dick.
1919—J. McF. Bergland, Philip Briscoe, J. E. Deets.
1920—T. R. Boggs, A. M. Shipley, Eugene Jones.
1921—J. H. M. Knox, Jr., A. H. Hawkins, C. E. Davidson.
1922—Harry Friedenwald, W. R. White, J. S. Bowen.
1923—J. M. H. Rowland, Harry Friedenwald, Peregrine Wroth, Jr.
1924—C. Urban Smith, J. Percy Wade, E. E. Wolff.
1925—J. S. Bowen, T. B. Johnson, J. McF. Dick.
1926—Standish McCleary, G. Roger Myers, S. A. Nichols.
1927—Standish McCleary, John L. Riley, Frank S. Keating.
1928—J. Albert Chatard, F. B. Hines, R. T. Miller, Jr.
1929—Henry M. Fitzhugh, Robert P. Bay, Thomas R. Boggs.
1930—F. D. Chappelear, W. T. Hammond, F. B. Hines.
1931—W. D. Campbell, H. M. Lankford, Charles Maxson.
1932—W. T. Hammond, John T. King, Jr., Lewis K. Woodward.
1933—S. A. Nichols, E. H. Hutchins, W. S. Seymour.
1934—G. C. Lockard, W. R. White, J. L. Riley.
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1936—Harvey G. Beck, Norman S. Dudley, Jesse O. Purvis.
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1946—William D. Noble, Grant E. Ward, John S. Green, Jr.
1947—Huntington Williams, Frank M. Wilson, J. Herbert Bates.
1948—William Neill, Jr., Baltimore; Samuel E. Enfield, Cumberland; F. Seton Waesche, Snow Hill.
1949—Amos R. Koontz, Baltimore; O. H. Binkley, Hagerstown; P. E. Cox, Easton.
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1951—Samuel McLanahan, Baltimore; Frank D. Worthington, Frederick; Frank W. Smith, Chestertown.
1952—Frank J. Geraghty, Baltimore; W. A. Gracie, Cumberland; Deceased 12-28-51; William F. Williams, Cumberland; R. Carmichael Tilghman, Baltimore.
1953—George O. Eaton, Baltimore; Osborne D. Christensen, Salisbury; William F. Williams, Cumberland.
1954—E. Paul Knotts, Denton; Ernest I. Cornbrooks, Jr., Baltimore; Ralph G. Hills, Baltimore.

1955—Waldo B. Moyers, Hyattsville; Samuel Whitehouse, Baltimore; Charles J. Foley, Havre de Grace.

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1958—Archie R. Cohen, Clear Spring; Alfred R. Maryanov, Cambridge*; Grant E. Ward, Baltimore.

ACTIVE MEMBERS OF COMPONENT SOCIETIES

Allegany-Garrett County

Alvarez, Joseph, 101 3rd Street, Oakland, Md.
Ballin, R. W., 62 Greene Street, Cumberland, Md.
Baumgartner, E. I., Oakland, Md.
Benjamin, Gilbert W., Hillen Station, Western Md. Ry., Baltimore 2, Md.
Brings, Elizabeth, 55 Greene Street, Cumberland, Md.
Brings, Lewis, 57 Greene Street, Cumberland, Md.
§Brinsfield, Carlton, 232 Baltimore Avenue, Cumberland, Md.
Broadrup, E. E., 202 Virginia Avenue, Cumberland, Md.
Cawley, Frank, Memorial Hospital, Cumberland, Md.
*Cowherd, J. Kile, 41 Greene Street, Riverside Building, Cumberland, Md.
§Daugherty, L. E., 7 Washington Street, Cumberland, Md.
Davis, John B., 2 Broadway, Frostburg, Md.
*Deming, Herbert V., 240 N. Centre Street, Cumberland, Md.
Devers, John C., Frostburg, Md.
Diehl, H. C., Frostburg, Md.
Doerner, Wyand, F., Algonquin Hotel, Cumberland, Md.
Durrett, Clay Earl, 236 Virginia Avenue, Cumberland, Md.
Eliason, H. W., 126 Union Street, Cumberland, Md.
Faw, Wylie M., Jr., 5 Washington Street, Cumberland, Md.
Feaster, James, Oakland, Md.
Feddis, Robert, 39 Greene Street, Cumberland, Md.
*Frantz, Winter R., City Hall, Cumberland, Md.
Gardner, Charlotte B., 126 Columbia Street, Cumberland, Md.
Gattens, Wilbur E., Frostburg, Md.
§Grove, Donald B., 122 S. Centre Street, Cumberland, Md.
Hadidian, Calvin Y., Hotel Algonquin, Cumberland, Md.
Hallinan, James P., 140 Bedford Street, Cumberland, Md.
§Harrat, Frank T., 26 Mechanic Street, Frostburg, Md.
Himmelwright, George O., 133 Virginia Avenue, Cumberland, Md.
Hodges, W. R., Jr., 122 Centre Street, Cumberland, Md.
Iames, William, 441 N. Centre Street, Cumberland, Md.
Jacobson, Samuel M., Pershing Street, Cumberland, Md.
Johnson, James T., Jr., 16 Greene Street, Cumberland, Md.
Jones, Emmett L., Jr., 50 Pershing Street, Cumberland, Md.
Kroll, Mark, 110 S. Centre Street, Cumberland, Md.
Leighton, Herbert H., Oakland, Md.
Lewis, Thomas Franklin, 5 Washington Street, Cumberland, Md.
Ley, Leo H., Jr., 456 N. Centre Street, Cumberland, Md.
Lusby, Thomas F., 121 Bedford Street, Cumberland, Md.
McLane, W. Oliver, Jr., 167 E. Main Street, Frostburg, Md.
Mance, A. E., Oakland, Md.
Miles, Leslie R., Jr., 27 Main Street, Lonaconing, Md.
Miller, David H., 22 Washington Street, Cumberland, Md.
§Mirkin, A. J., 115 South Centre Street, Cumberland, Md.
Mould, Leslie L., 122 S. Centre Street, Cumberland, Md.
Mozzer, Alexander J., W. Md. Ry. Bldg., One S. Canal Street, Cumberland, Md.
Murray, Francis A. C., Route 6, Cumberland, Md.
Owens, Charles L., 305 Washington Street, Cumberland, Md.
Paul, Earl, 36 Greene Street, Cumberland, Md.
Peachey, Ruth, Grantsville, Md.
Ranson, Leland B., 63 Greene Street, Cumberland, Md.
Rathbone, R. R., 122 S. Center Street, Cumberland, Md.
Rees, David T., 703 Montgomery Avenue, Cumberland, Md.
Reeves, J. Norman, Westernport, Md.
Reeves, Raymond W., Westernport, Md.
Reiter, Ralph A., 112 Bedford Street, Cumberland, Md.
Roth, Oliver Ralph, 427 Goethe Street, Cumberland, Md.
Rothstein, Martin M., Frostburg, Md.
Schindler, Blaine M., 41 Greene Street, Cumberland, Md.
Simons, George, 128 Union Street, Cumberland, Md.
Skitarelic, Benedict, Memorial Hospital, Cumberland, Md.
Stegmaier, James G., Medical Building, 122 S. Centre Street, Cumberland, Md.
Tepfer, Milton, Friendsville, Md.
Tolson, Howard L., 122 S. Centre Street, Cumberland, Md.
Topper, John, Hyndman, Penna.
§Trevaskis, R. W., 220 Baltimore Avenue, Cumberland Md.
Trevaskis, R. W., Jr., 220 Baltimore Avenue, Cumberland, Md.
Van Ormer, W. Alfred, Medical Building, 122 S. Centre Street, Cumberland, Md.
Walters, Hilda Jane, 48 Broadway, Frostburg, Md.
Weisman, Saville G., 59 Greene, Street, Cumberland, Md.
Wenzel, J. W., Oak & Eighth Streets, Oakland, Md.

* Deceased.
§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

Whitworth, Fuller B., 123 Bedford Street, Cumberland, Md.
Williams, Richard Jones, 122 S. Centre Street, Cumberland, Md.
Williams, W. F., 122 S. Centre Street, Cumberland, Md.
Wolferman, Adolf, 36 Greene Street, Cumberland, Md.
Zimmermann, Charles Conrad, 105 S. Centre Street, Cumberland, Md.

Anne Arundel County

Alden, Manning W., Dept. of Pathology, Anne Arundel General Hospital, Annapolis, Md.
Alexander, John G., Crain Highway & 2nd Avenue, Glen Burnie, Md.
Allen, Aris Tee, 62 Cathedral Street, Annapolis, Md.
Allen, Faye W., 62 Cathedral Street, Annapolis, Md.
Anderson, Albert L., 44 Southgate Avenue, Annapolis, Md.
Armstrong, Robert H., Jr., Anne Arundel General Hospital, Annapolis, Md.
Ball, Charles L., Jr., 203 W. Maple Road, Linthicum Heights, Md.
Beard, J. Howard, Box 626, Annapolis, Md.
Beck, Edward S., 41 Southgate Avenue, Annapolis, Md.
Benedict, Ludwig, Crownsville, Md.
Borssuck, Samuel, Amos Garrett Boulevard, Annapolis, Md.
Briscoe, Philip, 95 Cathedral Street, Annapolis, Md.
Christhilf, Stuart, Jr., 69 Franklin Street, Annapolis, Md.
§Codd, Francis I., Severna Park, Md.
Davis, Edwin, Jr., 98 Cathedral Street, Annapolis, Md.
Di Marco, Beatrice, 59 Franklin Street, Annapolis, Md.
Faubert, Gustav H., 5 First Avenue, S.E., Glen Burnie, Md.
Field, Edward G., 1 Crain Highway, Box 146, Glen Burnie, Md.
§Flax, Leonard H., 113 7th Avenue, Brooklyn Park, Baltimore 25, Md.
French, William J., 116 Duke of Gloucester Street, Annapolis, Md.
§Gaalaas, A. F., 10815 53rd Avenue, North, St. Petersburg, Fla.
Grant, Bowie Lynn, A03001769, 160 3rd USAF Hospital, APO 231, % P.M., New York, N. Y.
Grimaldi, Pasquale J., 4609 Governor Ritchie Highway, Baltimore 25, Md.
Hadley, Henry G., 1252—6th Street, S.W., Washington 4, D. C.
Hahn, Robert R., Severna Park, Md.
Hamilton, John M., Crownsville State Hospital, Crownsville, Md.
Hawkins, John Frederick, Jr., Dividing Road, Manhattan Beach, Severna Park, Md.
Hedeman, John L., 90 Cathedral Street, Annapolis, Md.
§Hendricks, Franklin D., Cathedral & Dean Streets, Annapolis, Md.
Johnson, Theodore H., 37 Calvert Street, Annapolis, Md.
Jones, Bryant L., 104 S. Crain Highway, S.W., Glen Burnie, Md.
Jones, Harry N., 1520- 9th Street, N.W., Washington, D. C.
Katz, Selig H., R.F.D. 3, Box 75, Annapolis, Md.
Klawans, Maurice F., 31 Southgate Avenue, Annapolis, Md.
Klinger, Stephen, 5107 Birchwood Drive, Oxon Hill, Washington 21, D. C.
Lankford, Arthur, Jr., Mountain Road, Route 8, Pasadena, Md.
Lim, Sylvia M., R.F.D. #1, Box 277-M, Edgewater, Md.
§Linhardt, Elmer G., 3 Chesapeake Avenue, Eastport, Md.
Linthicum, Charles M., 106 W. Maple Road, Linthicum Heights, Md.
Loebl, Julius, 204 Crain Highway-S., Glen Burnie, Md.
Lyons, John Gorman, 115 Spa View Avenue, Annapolis, Md.
Lyons, Kathleen Hausmann, Paisley Road, Gibson Island, Md.
MacDonald, Charles R., Box 296, Glen Burnie, Md.
McLaughlin, Randall, R.F.D. 6, Box 372, Pasadena, Md.
Manuzak, Hubert F., Eastway & Edgerly Road, Harundal, Glen Burnie, Md.
Mapp, Lionel McHenry, Crownsville State Hospital, Crownsville, Md.
Martin, James R., 6 Shaw Street, Annapolis, Md.
Monias, Michael B., 69 Franklin Street, Annapolis, Md.
Norton, Clayton, Box #1, Route #1, Arnold, Md.
Morgenstern, Jacob, 916 Ridgewood Street, Annapolis, Md.
Mosser, Robert S., 3 Central Avenue, Glen Burnie, Md.
Peller, Richard Nevin, Box 162, Route 4, Annapolis, Md.
Ochs, Irving L., 51 Southgate Avenue, Annapolis, Md.
Perry, Leon C., 201 Baltimore & Annapolis Boulevard, Glen Burnie, Md.
Phillips, George McK., Crownsville State Hospital, Crownsville, Md.
Purvis, Jesse Oliver, 40 Franklin Street, Annapolis, Md.
Reddy, John B., 59 Franklin Street, Annapolis, Md.
Richardson, R. L., 110 Clay Street, Annapolis, Md.
§Riley, Robert Annan, Jr., 69 Franklin Street, Annapolis, Md.
Rodler, Edith, 45 Franklin Street, Annapolis, Md.
Russell, John T., 113 Chesapeake Avenue, Eastport, Md.
Sargeant, Stanley C., Crownsville, Md.
Stephens, William P., U. S. Naval Hospital, Annapolis, Md.
Sheehan, Joseph Chester, 69 Franklin Street, Annapolis, Md.
Shipley, Frank M., 63 College Avenue, Annapolis, Md.
Sims, Neil H., 95 Cathedral Street, Annapolis, Md.
Skerritt, Edward G., Box 7, Gambrills, Md.
Sosnowski, A. R., 4016 Ritchie Highway, Baltimore 25, Md.
Szabo, Andrew D., 701 Berry Road, Glen Burnie, Md.
Taler, Joseph, 102 Baltimore-Annapolis Boulevard, Glen Burnie, Md.
Thomas, William N., Jr., 5 Boone Trail, Severna Park, Md.
Trettin, G. Douglas, Severna Park, Md.
Vogel, Otto, Box 441-A, Route 8, Pasadena, Md.
Waite, Merton T., Cathedral & Deane Streets, Annapolis, Md.
Walker, Stuart H., 184 Prince George Street, Annapolis, Md.
Ward, Charles S., Crownsville State Hospital, Crownsville, Md.
Warner, Mary P., 108 Monticello Avenue, Annapolis, Md.
Weber, Konstantin, Crownsville State Hospital, Crownsville, Md

§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

Weitzman, F. E., 130 Lafayette Avenue, Annapolis, Md.
Welch, Robert S. G., 86 State Circle, Annapolis, Md.
Wilkins, Jesse Lee, 232 Prince George Street, Annapolis, Md.
Wilson, Emily Hammond, Lothian P.O., Md.
Wright, J. Leroy, 2539 Pickwick Road, Baltimore 7, Md.
Yosuico, Jose M., R.F.D. #1, Jessups, Md.

Baltimore City

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§Abbott, Thomas G., 4509 Liberty Heights Avenue—7
Abercrombie, Ronald T., 100 W. University Parkway—18
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Alessi, Silvio A., 6217 Harford Road—14
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Ankudas, Stanley, 847 Glen Allen Drive—29
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§Ashman, Leon, 5907 Gwynn Oak Avenue—7
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§Askin, John A., 1401 Reisterstown Road—8
Asper, Samuel P., Jr., Johns Hopkins Hospital—5
Atkins, Raymond, 1623 Stonewood Road—12
Ayd, F. J., 2005 E. Monument Street—5
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Babb, Dudley C., 1100 N. Charles Street—1
Bacharach, David, 6027 Berkley Avenue—9
Bacher, Norman M., University Hospital—1
Baermann, Wilhelm E., 33 Dundalk Avenue—22
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Baggott, Bartus T., 3812 Greenmount Avenue—18
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*Bagley, Charles, Jr., Kingsville, Md.
§Bagley, Charles, III, University Hospital—1
Bahnson, Henry T., Johns Hopkins Hospital—5
§Bakal, Daniel, 3305 Dorithan Road—15
Baker, Benjamin May, Jr., 9 E. Chase Street—2
Baker, Frank W., Jr., 6222 The Alameda—12
Baldwin, Ruth Workman, University Hospital—1
*Ball, Peter, 1834 Glen Ridge Road—4
Ballard, Margaret B., Medical Arts Building—1
Ballich, Nicholas L., 11 E. Chase Street—2
Band, Raymond I., 1665 Northern Parkway—12
§Banfield, Gilbert L., 722 N. Fulton Avenue—17
§Barczak, Edward M., 816 Wellington Road—12
§Barnaby, John W., Jr., 1531 E. North Avenue—13
§Barranco, Salvatore H., 436 E. Fort Avenue—30
§Bartemier, Leo H., Seton Institute—15
Battaglia, Dominic Thomas, 5829 Belair Road—6
Bauer, Robert E., Dept. of Medicine, University Hospital—1
Baum, Max, 3834 Menlo Drive—15
§Bawden, George Abner, 323 Medical Arts Building—1
Baylin, Morris J., 5418 Park Heights Avenue—15
Baylus, Herman H., 1600 Wilkens Avenue—23
Baylus, Meyer Milby, 3234 Eastern Avenue—24
§Beacham, Edmund George, 710 Thornwood Court—4
Beck, George H., 2102 Woodbourne Avenue—14
§Beck, Harry McBrine, 120 Midhurst Road—12

* Deceased.
§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

§Beck, Nathaniel M., 2818 St. Paul Street—18
Bell, Herbert S., 2314 Ocala Avenue —15
Benesuns, Joseph G., 110 E. Lombard Street—2
Bennett, George E., 4 E. Madison Street—2
Bennett, Ivan L., Jr., 311 Broxton Road—12
§Benson, Carl F., 5111 York Road —12
Benson, Donald Warren, Dance Mill Road, Phoenix, Md.
§Benson, William P., Jr., 3601 Greenway—18
Benz, Carl F., 215 Gittings Avenue —12
Berblinger, Klaus William, 2444 Pickwick Road—7
Berdann, Benjamin, 7809 Liberty Road—7
Bereston, Eugene S., 22 E. Eager Street—2
Berger, Ronald R., 2914 B. Wynham Road—16
Bergland, J. McF., 1014 St. Paul Street—2
Bergner, Lawrence, Baltimore City Hospitals—24
§Berkow, Morton D., 6809 Pimlico Drive—9
Berman, Barnett, 714 Park Avenue —1
Berman, Edgar F., 701 Cathedral Street—1
Bernheim, Bertram M., Woodholme Avenue—8
Bernstein, Alan, 819 Park Avenue—1
Berry, Robert Zinn, 211 Medical Arts Building—1
Bessman, Alice N., 2708 Roslyn Avenue—16
Bessman, Samuel P., 2708 Roslyn Avenue—16
Besson, Edwin H. T., 410 Locust Drive—28
Bestebreurtje, Annie M., 300 Somerset Road—10
Betz, Barbara J., 800 Malvern Avenue—4
Biehl, Harold Paul, 11 E. Chase Street—2
Bierman, Joseph S., 1206 Bolton Street—17
Bing, James F., 609 Cathedral Street—1
Bird, Edward Dennis, Baltimore City Hospitals—24
Bishop, George W., Sheridan Avenue & York Road—12
Bix, Hans, 2516 Linden Avenue—17
Blalock, Alfred, Johns Hopkins Hospital—5
Blanchard, Cyrus L., 111 Oella Avenue—28
Biazek, Charles Joseph, 914 N. Charles Street—1
Blechman, A. Joel, 3426 Bank Street—24
Block, Walter P., 509 Drury Lane —29
Bloedorn, Fernando G., Dept. of Radiology, University Hospital —1
Blue, Morris Larrie, 4503 "C" Wakefield Road—16
§Blum, Joseph S., 1115 N. Calvert Street—2
Blum, Louis V., 2310 Eutaw Place —17
Blumberg, Jerome Joachim, 4917 Park Heights Avenue—15
Blumenfeld, Herbert L., 2837 Boarman Avenue—15
Blumenfeld, Samuel, 5500 Winton Avenue—7
Bodenheimer, Ernst, 1212 Eutaw Place—17
Boggio, Joseph P. C., 7811 High Point Road—14
Bogorad, Daniel E., 1905 W. Baltimore Street—23
§Bohlman, Harold R., 96 Cathedral Street, Annapolis, Md.
§Bongardt, H. F., 201 W. Madison Street—1
Borden, Jesse Nachlas, 819 Park Avenue—1
Borden, Melvin N., 5000 Baltimore National Pike—29
Bordley, John Earle, Johns Hopkins Hospital—5
§Borges, Francis J., 1321 Heather Hill Road—12
§Borkovic, George William, 1318 Glendale Road—12
Borkovich, Katherine H., 11 E. Chase Street—2
Boss, M. Theodore, Medical Arts Building—1
Boudreau, Robert P., 321 Franklin Avenue, Geneva, Ill.
Bowe, Dudley Pleasants, 2 W. Read Street—1
§Bowie, Harry C., 926 St. Paul Street—2
Bowie, Helen, 2941 St. Paul Street —18
§Bowyer, Thomas S., Medical Arts Building—1
Boyd, C. Holmes, 24 E. Eager Street—2
Boyle, J. Brooke, Jr., 2843 St. Paul Street—18
§Brack, C. Bernard, 11 E. Chase Street—2
Bradley, Albert B., 4900 Belair Road—6
Bradley, J. Edmund, University Hospital—1
Bradley, Samuel M., 7913 Beverly Road—14
Brady, Charles W., 127 Grove Street, Waterbury, Conn.
§Brady, Frank Joseph, 4530 Marble Hall Road—12
§Brady, Leo, Medical Arts Building—1
Brager, Simon, 1800 N. Charles Street—1
Brailey, Miriam E., Osler 201, Johns Hopkins Hospital—5
Brannon, William, 145 Harding Road, New Orleans, La.
§Brantigan, Otto C., 104 W. Madison Street—1
*Breitstein, Moses L., 4504 N. Charles Street—10
Brennan, Thomas Joseph, 5217 Harford Road—14
Brody, Eugene B., University of Maryland Psychiatric Institute—1
Bronushas, I. B., 3037 O'Donnell Street—24
Bronushas, Joseph B. B., 3037 O'Donnell Street—24
Brooks, James B., 4 E. Madison Street—2
§Brooks, Ross C., 2512 E. Monument Street—5
Brouillet, George Hector, 102 Dunkirk Road—12
Brown, Ernest Claiborne, Jr., 1101 N. Calvert Street—2
Brown, Hugh Michael, 1103 St. Paul Street—2
Brown, James, 705 Medical Arts Building—1

* Deceased.
§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

*Brown, Paul, 3602 Liberty Heights Avenue—17
Brown, Webster H., 11 E. Biddle Street—2
Browne, Rayner, 1500 E. Madison Street—5
Broyles, Edwin N., 1100 N. Charles Street—1
Brumback, Joseph Edw., Medical Arts Building—1
Brumback, Joseph E., Jr., 212 Goodale Road—12
Bubert, Howard M., Medical Arts Building—1
Buchness, Anthony V., 110 E. Lombard Street—2
Buchness, John A., 110 E. Lombard Street—2
Buck, Walter B., 18 E. Eager Street—2
Bundick, William R., 840 Park Avenue—1
Burger, T. Terry, 3301 N. Charles Street—18
Burgin, Bernard, 6721 Reisterstown Road—15
Burkhart, Thomas Joseph, 1126 McHenry Street, Arundel Hills, Glen Burnie, Md.
Buxton, Robert W., University Hospital—1
§Byerly, M. Paul, 3033 W. North Avenue—16
Byrnes, Bernard Joseph, Jr., 4112 Erdman Avenue—13
Cader, Gordon, 714 Park Avenue—1
Cahn, Charles A., 2145 W. Baltimore Street—23
Callaway, Enoch, III, University Hospital—1
Camp, Leah Rosenblatt, Church Lane, Chestnut Hill Estates, R #3, Ellicott City, Md.
Camp, Oscar B., Church Lane, Chestnut Hill Estates, R #3, Ellicott City, Md.
§Campbell, Charles R., 718 Dolphin Street—17
Cantrell, James R., Johns Hopkins Hospital—5
Caplan, Lester H., 1401 Reisterstown Road—8
§Carey, T. Nelson, 1014 St. Paul Street—2
Carozza, Anthony F., 5217 York Road—12
Carr, Charles E., Jr., 6201 York Road—12
Carroll, H. Roland, 4202 Charlcote Road—18
§Carroll, John E., Jr., 715 Park Avenue—1
Casler, DeWitt B., 21 Blythewood Road—10
Castagna, Joseph V., 4316 St. Paul Street—18
Castellano, James, Jr., Relay Hill Hospital, Baltimore 27, Md.
Catlin, Francis Irving, 720 Morningside Drive—4
Cavallaro, Joseph W., % Veterans Administration Hospital, Oklahoma City, Okla.
§Chalfant, Archibald S., 6210 York Road—12
§Chambers, Earl L., 4108 Liberty Heights Avenue—7
Chambers, Ewan Buchanan, 3408 St. Paul Street—18
Chambers, John W., 18 W. Franklin Street—1
Chambers, Robert G., 1708 Ruxton Road—4
§Chambers, Thomas R., 18 W. Franklin Street—1
Chandler, Caroline A., 2411 N. Charles Street—18
Chang, Francis F. C., 6223 Chinquapin Parkway—12
Chant, Harry L., Johns Hopkins Hospital—5
Checket, Pierson M., 1801 N. Eutaw Place—17
§Chenowith, Robert F., 1114 St. Paul Street—2
Cherry, Jerrie, 04069912, 249 General Dispensary, APO 259, New York, N. Y.
§Chesney, Alan M., 1419 Eutaw Place—17
Chesnut, Roy W., Jr., 1305 Park Avenue—17
Chinard, Francis P., 25 Overhill Road—28
Chiodi, Nathan E., Apt. 3-I, 1010 St. Paul Street—2
Chisolm, James Julian, 6 E. Eager Street—2
Chisolm, James Julian, Jr., Baltimore City Hospitals—24
Chiu, Chi-Chao, 1 E. Randall Street—30
Church, Marguerite L., Hillcrest Farm, Ridge Road—7
Clark, David Barrett, Neurology, Room 403 Osler, Johns Hopkins Hospital—5
Classen, John Newell, 2923 St. Paul Street—18
Cleary, Louis F., 6420 Reisterstown Road—15
Clemmens, Raymond L., 522 Goucher Boulevard—4
§Clemson, Earl P., 701 Cathedral Street—1
Clough, Paul W., 24 E. Eager Street—2
Cluff, Leighton E., 8729 Oakleigh Road—34
§Coblentz, Richard G., 11 E. Chase Street—2
Codington, John Bonnell, 6004 Hillen Road—12
Coffay, E. Paul, Jr., 2843 St. Paul Street—18
§Cohen, Bernard J., The Marylander Apartments, 3501 St. Paul Street—18
§Cohen, B. Stanley, 7306 Liberty Road—7
Cohen, Harry, 701 Cathedral Street—1
Cohen, Irvin H., 14 E. Biddle Street—2
Cohen, Jonas Harold, 6702 Park Heights Avenue—15
§Cohen, Morris M., 1115 St. Paul Street—2
Cohn, L. Clarence, 3600 Labyrinth Road, Apt. D-11—15
§Cole, Alfred, 136 S. Hilton Street—29
Cole, Norman Brown, The University Club—1
§Collenberg, Henry T., 2 W. Read Street—1
Coller, Jerome J., 2217 South Road—9
Collins, James M., 3321 Frederick Avenue—29
Colsky, Sol, 4025 Hilton Road—15
Colston, J. A. Campbell, Johns Hopkins Hospital—5
Colston, John A. C., Jr., 601 N. Broadway, Johns Hopkins Hospital—5
§Compton, Beverley C., 1014 St. Paul Street—2
Conley, C. Lockard, 120 E. Lake Avenue—12

* Deceased.
§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

Conn, Jacob H., 2325 Eutaw Place —17
Connolly, Harry John, 13 E. Eager Street—2
Conway, William M., 5511 Purdue Avenue—12
§Cook, E. Ellsworth, Jr., 2431 Maryland Avenue—18
Cooke, Robert E., Rackham Road, Gibson Island, Md.
Cooper, Donald D., 100 Burke Avenue—4
Cooper, Theodore, 5320 Park Heights Avenue—15
Coplan, Robert S., 2111 Carterdale Road—9
§Copeland, Herbert B., 2237 Eutaw Place—17
Cordi, Joseph M., Loch Raven Shopping Center, Loch Raven Boulevard & Northern Parkway —12
Cornblath, Marvin, 2505 W. Belvedere Avenue—15
§Cornbrooks, Ernest I., Jr., 521 Medical Arts Building—1
§Corner, George W., Jr., 3332 St. Paul Street—18
Costantini, John, 234 S. Conkling Street—24
§Cotter, Edward Francis, 6 E. Read Street—2
Covington, E. Eugene, 828 Park Avenue—1
Cowley, R Adams, 3601 Greenway, Apt. 607-A—18
§Cox, William F., III, 1118 St. Paul Street—2
Crimy, Charles P., 2722 E. Monument Street—5
Crocker, Melvin H., 1204 St. Paul Street—2
Crosby, Robert M. N., 2 W. Read Street—1
Cross, Ernest S., 410 Gittings Avenue—14
Cross, Ernest S., Jr., Medical Arts Building—1
§Cross, Richard J., 104 W. Madison Street—1
Crowther, Aloho H., 4209 Frederick Avenue—29
Cumin, Milton H., 4302 Springdale Avenue—7
§Cunningham, Raymond M., 11 E. Chase Street—2
Currie, Dwight McI., 11 E. Chase Street—2
§Curtis, Raymond M., 2919 St. Paul Street—18
Cushner, Irwin M., 3105 N. Charles Street—18
Cytryn, Leon, 5605 Haddon Avenue —7
Dana, Edward R., 4214 Greenway —18
§Dandy, Walter E., Jr., 6000 Hunt Club Lane—10
Daniels, Thomas F., 6 E. Eager Street—2
Daniels, Worth Bagley, Jr., Baltimore City Hospitals—24
§D'Antonio, Joseph, 2202 Boxmere Road—4
Darby, William A., Medical Arts Building—1
Davidov, Nathan J., 3218 Eastern Avenue—24
§Davidson, Charles Nuchols, 5900 Lakehurst Avenue—10
Davidson, David Lee, Baltimore City Hospitals—24
Davidson, Nachman, 2403 Ken Oak Road—9
Davies, Arthur J., 104 Enfield Road —12
§Davis, E. Hollister, 3301 N. Charles Street—18
Davis, Frank W., Jr., 11 E. Chase Street—2
Davis, John R., 6629 Charlesway—4
Davis, Marvin Hersch, 3601 Patterson Avenue—7
Davis, Ruth Alice, 600 W. 111th Street, Apt. 3-E, New York 25, N. Y.
Davis, W. Bowdoin, 600 W. Belvedere Avenue—10
§Day, Newland E., 4 E. 33rd Street —18
Deane, Garrett E., 5402 Edmondson Avenue—29
De Borja, Pedro S., 1020 Armstead Way—5
§Debuskey, Matthew, 2505 W. Belvedere Avenue—15
De Carlo, John, Jr., 701 Seabrook Court—4
Deckelbaum, Joseph, 4017 Liberty Heights Avenue—7
Deckert, W. Allen, 1114 St. Paul Street—2
De Hoff, George W., 2020 N. Charles Street—18
§De Hoff, John Burling, 2020 N. Charles Street—18
DeKornfeld, Thomas J., 200 Hopkins Road—12
Delfs, Eleanor, Johns Hopkins Hospital—5
Demarco, Salvatore J., Jr., 715 N. Charles Street—1
Dembo, Donald H., 2319 Monticello Road—16
§Dennis, John Murray, University Hospital—1
Denny, Walter L., Brady Urological Institute, Johns Hopkins Hospital—5
Derome, Gilles A., 3201 Rueckert Avenue—14
De Vincentis, Michael Louis, 11 E. Chase Street—2
Dickson, Robert John, 830 W. University Parkway—10
Diehl, William K., 11 E. Chase Street—2
Diener, Louis, 2449 Eutaw Place—17
§Diggs, Everett S., 11 E. Chase Street—2
DiPaula, Anthony F., 5301 Harford Road—14
§Dix, Harold C., 405 N. Charles Street—1
Dixon, Alfred Burton, 3501 St. Paul Street, Apt. 5—18
§Dixon, D. McClelland, 819 Medical Arts Building—1
§Dobihal, Louis Charles, 447 N. Kenwood Avenue—24
Dodd, William A., 700 N. Charles Street—1
Doeller, Charles Henry, Jr., 11 E. Chase Street—2
Donner, Leon, 4023 Brookhill Road —15
Doran, William T., Jr., 131 C. Street, S.E., Washington 3, D. C.
§Dorf, Herman J., 7404 Liberty Road—7
§Dorman, John William, Jr., 1305 Round Hill Road—18
Douglass, Carleton C., 15 E. Biddle Street—2
Douglass, Louis H., Mount Custis, Accomac, Va.
Doukas, James A., 4008 Bedford Road—7
Drenga, Joseph F., 209 S. Chester Street—31
Drozd, Joseph, 240 S. Ann Street—31
Dudley, Albert Henry, Jr., 1201 N. Calvert Street—2

§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

Duffy, William C., 1120 St. Paul Street—2
Dugan, Francis M., 15 E. Biddle Street—2
§Dugan, Hammond J., Jr., 15 E. Biddle Street—2
Duke, James R., 601 N. Broadway—5
Dumler, John C., Medical Arts Building—1
Dumler, John Donald, McAlpine & Crestleigh Roads, Crestleigh R.F.D. 5, Ellicott City, Md.
Dunnigan, William C., 4916 Harford Road—14
§Dwyer, Frank P., Jr., 216 Montrose Avenue—28
Easterling, W. Sidney, 503 Guaranty Bank Building, Alexandria, Va.
Eastland, J. Sheldon, Medical Arts Building—1
§Eastman, Nicholson J., Johns Hopkins Hospital—5
§Eaton, George O., 4 E. Madison Street—2
Eaton, W. Drummond, 11 E. Chase Street—2
Eavey, James L., 3901 N. Charles Street—18
§Ebeling, Karl W., 5200 Tilbury Way—12
§Ebeling, William Carl, 809 Medical Arts Building—1
Edel, J. Wesley, Charleston Hall, Charles & Cold Spring Lane—10
Edgerton, Milton T., Johns Hopkins Hospital—5
Edmonds, Charles William, 2746 The Alameda—18
Edmunds, Page, Gibson Island, Md.
§Edwards, C. Reid, 314 Medical Arts Building—1
Edwards, Monte, Medical Arts Building—1
Ehrlich, Daniel, 701 Cathedral Street—1
Eisenberg, Leon, 2610 Whitney Avenue—15
Eisner, Victor, 2635 N. Charles Street—18
Eleder, Franklin C., 2201 Echodale Avenue—14
§Elgin, William W., Sheppard & Enoch Pratt Hospital—4
§Ellis, Francis A., 8 E. Madison Street—2
§Ellison, Emanuel S., 107 E. West Street—30
Eney, R. Donald, 12 York Road—4
Englehart, William P., 112 Dunkirk Road—12
§English, Max R., 5713 Belair Road—6
Entwisle, George, 802 Shaw Court—4
*Erwin, John J., Medical Arts Building—1
Esmond, William George, 5018 Old Frederick Road—29
Everett, Houston S., 11 E. Chase Street—2
Everett, John Thomas, 3501 Fait Avenue—24
§Ewald, August Ludwig, 36 York Court—18
Faraino, Frank A., 2 W. Read Street—1
§Farber, George J., 1037 St. Paul Street—2
Farber, Mary S., 305 Woodlawn Road—10
Farber, Robert E., 305 Woodlawn Road—10
§Farfel, Harold Seymour, 700 Stamford Road—29
Farley, Julie, 418 Northway—18
Farrow, Royal Thomas, 403 Fourth Street, Riverton, New Jersey
§Fearing, William L., 3025 Belair Road—13
Feinglos, Israel J., 2002 E. Pratt Street—31
Feldberg, Theodore M., 5504 S. Bend Road—9
Feldman, Martin J., 1 Cherry Hill Road, Reisterstown
Feldman, Maurice, 3602 Fords Land—15
Feldman, Maurice, Jr., The Latrobe, Charles and Read Streets—2
Feldman, S. Charles, 1440 E. Baltimore Street—31
§Fenby, John S., 3522 Greenmount Avenue—18
§Ferguson, W. Richard, 600 W. Belvedere Avenue—10
Fetter, William Joseph, 1511 Lakeside Avenue—18
Field, Arnold Lewis, 901 Cathedral Street—1
Filtzer, David Leonard, 2500 Eutaw Place—17
Finberg, Lawrence, 6811 Pimlico Road—9
§Fine, Jack, 3331 Clarks Lane—15
Fineman, Jerome, 4004 Liberty Heights Avenue—7
Finesinger, Jacob Ellis, Dept. of Psychiatry, University of Maryland School of Medicine—1
Finkelstein, A. H., 11 E. Chase Street—2
Finkelstein, Ruth, 801 Medical Arts Building—1
§Finney, D. C. W., Union Memorial Hospital—18
§Finney, George G., 2947 St. Paul Street—18
Finney, John M. T., Jr., Seal Rocks Farm, Chester, Nova Scotia, Canada
Finney, Louis Arthur, Johns Hopkins Hospital—5
Firor, Warfield M., 1101 N. Calvert Street—2
§Firor, Whitmer B., 1100 N. Charles Street—1
Fishel, Elliott R., 3321 Essex Road—7
Fisher, A. Murray, 18 E. Eager Street—2
§Fisher, Russell S., 700 Fleet Street—2
Fitzpatrick, Vincent dePaul, Jr., 316 Broxton Road—12
Fitzpatrick, William N., 300 Somerset Road—10
Fleischer, Walter E., 3400 E. Chase Street—13
Fleisher, T. Lawrence, 8058 Mid Haven Road—22
Flippin, Eugene L., 4403 Underwood Road—18
Flynn, Philip D., 203 Taplow Road—12
Fordyce, Cless Y., 1001 St. Paul Street—2
§Fort, Wetherbee, 1118 St. Paul Street—2
Foster, Herbert M., 2824 St. Paul Street—18
Fox, Lay Martin, U. S. Naval Hospital, Chelsea 50, Mass.
Fox, Samuel L., 1205 St. Paul Street—2
Frank, Jerome D., 603 W. University Parkway—10
§Franklin, Haswell D., 1123 St. Paul Street—2

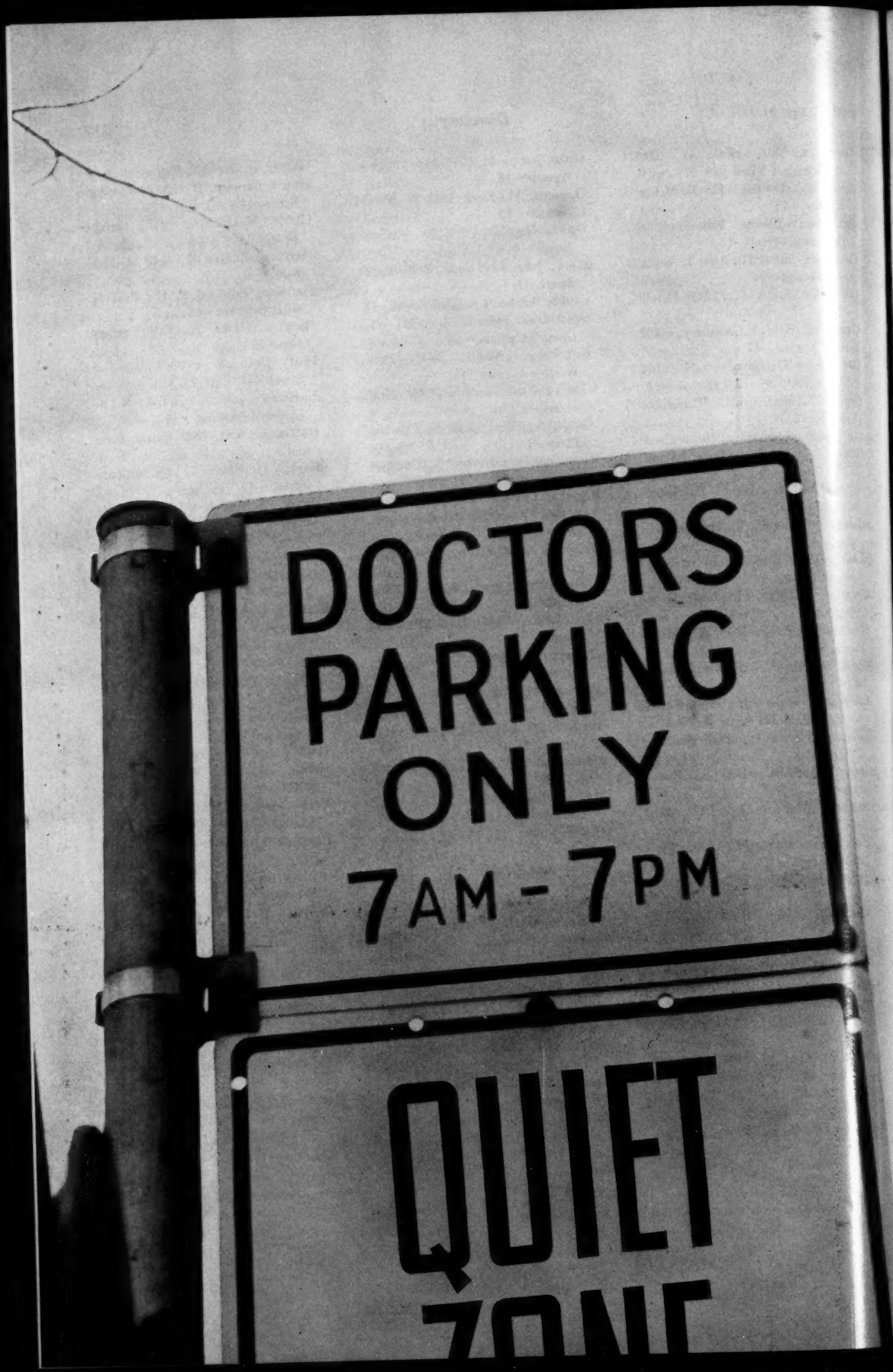
*Deceased.
§Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

§Franz, John Howard, 2938 St. Paul Street—18
Fravel, C. Richard, 926 Beaverbank Road—4
Frederickson, Howard N., 427 St. George Street, York, Pa.
§Freedom, Leon, 1031 St. Paul Street—2
Freeman, Gustave, 314 Taplow Road—12
§Freeman, Norman Randolph, Jr., 210 Northway—18
§Frenkil, James, 338 W. Pratt Street—1
Frey, Edward L., Jr., 4605 Edmondson Avenue—29
Frey, E. William, 1928 Pennsylvania Avenue—17
Fried, Hiram, Medical Arts Building—1
Friedenwald, Edgar B., Marlborough Apts., 1-B, 1701 Eutaw Place—17
§Friedman, Hyman P., 1319 Light Street—30
Friedman, Joseph, 404 East North Avenue—2
§Friedman, Marion, 1737 E. North Avenue—13
Friskey, George H., 4815 Wilkins Avenue—28
Fritz, Louis A., 1413 Shefford Road—12
Fritz, William F., 2 W. University Parkway—18
Frost, John Kingsburg, Fox Hunt Lane, Lutherville, Md.
§Fuller, Harvey L., 5718 Ridgedale Road—9
Furnari, Joseph C., University Hospital—1
Furstenberg, Frank F., 812 Park Avenue—1
Fusting, William H., 4230 Loch Raven Boulevard—18
Futcher, Palmer H., Department of Medicine, Johns Hopkins Hospital—5
§Gaber, Jerome, Stevenson P.O., Stevenson, Md.
Gaby, Samuel D., 2415 Diana Road—9
Gachet, Fred Smith, Jr., 1017 N. Broadway—5
Gaffney, George W., 28 Township Road—22
Gaines, Leonard Myrton, Jr., 1912 McElderry Street—5
Gaither, Ernest H., 12 E. Eager Street—2
§Gallant, Leonard J., The Latrobe—2
Galvin, Gerald A., 322 Suffolk Road—18
Gann, Donald Stuart, Falls Road, Cockeysville, Md.
Gann, Mark E., 1010 St. Paul Street—2
Gans, Jack S., 1747 Waverly Way—12
Gantt, William Horsley, Johns Hopkins Hospital—5
Gardner, Francis S., Jr., USAF (MC) 25640A, 7100th USAF Hospital, APO 633, New York, N. Y.
Gareis, Louis C., 1651 Northwick Court—18
§Garis, Robert William, 1103 S. Paul Street—2
Garlick, William L., 700 N. Charles Street—1
Garrison, Alfred S., 2 E. Read Street—2
Gaskel, Jason H., 637 S. Conkling Street—24
Gauld, John Ross, 1902 Amherst Road, Hyattsville, Md.
Gauthier, Donald W., 2903 Southern Avenue—14
Gaver, Leo J., 1 Mallow Hill Avenue—29
§Gay, Leslie N., 1114 St. Paul Street—2
Gebhardt, Robert William, 3711 Monterey Road—18
Gehlert, Sidney R., Jr., 4700 Pennington Avenue—26
Gellman, Moses, 2500 Eutaw Place—17
Genecin, Abraham, 714 Park Avenue—1
Gentry, William D., Jr., Cambridge Arms Apartments, Charles & 34th Street—18
Geraghty, Frank J., 3047 St. Paul Street—18
Geraghty, William R., 309 Northway—18
Gerlach, James Johnson, 4 E. Eager Street—2
Gerwig, John M., Jr., Lt. MC., USNR, 5600 N. 11th Street, Arlington, Va.
Gibbons, J. Robert, 3 Elmhurst Road—10
Giering, Herman J., 3906 Parkside Drive—6
Gill, Hugh C. F., 3710 Buckingham Road—7
Gillis, Andrew C., 1033 N. Calvert Street—2
Gillotte, Joseph P., Apt. 2 A, 5103 Williston Street—29
Gilmore, William E., 108 E. 33rd Street—18
Gimbel, Harry S., 4605 Edmondson Avenue—29
§Ginsburg, Leon, 529 N. Charles Street—1
Glaser, Kurt, University Hospital—1
Glass, Frederic A., 845 Park Avenue—1
Glassman, Lionel, 6002 Wallis Avenue—15
§Glick, Samuel S., 3914 Park Heights Avenue—15
*Gliedman, Lester H., Johns Hopkins Hospital—5
Gluck, Francis W., 100 W. University Parkway—10
Gluck, Julius C., 5356 Reisterstown Road—15
Goldbach, Leo J., 6 E. Eager Street—2
Goldberg, Herman Krieger, 807 Cathedral Street—1
Goldberg, Raymond B., 701 Cathedral Street—1
Goldberg, Sigmund, 12 E. Pratt Street—2
Goldberg, Sylvan D., 4412 Elderon Avenue—15
Goldberg, Victor, 1916 E. 30th Street—18
§Goldman, Abram, 3501 Powhatan Avenue—16
Goldman, Harris, 3507 Garrison Boulevard—15
Goldmann, Harry, 2326 Eutaw Place—17
§Goldsborough, Charles R., 2923 St. Paul Street—18
§Goldstein, A. E., 3505 N. Charles Street—18
Goldstein, Marvin, 5334 Liberty Heights Avenue—7
§Goldstein, Robert Bruce, 806 Reverdy Road—12
Goldstone, Herbert, 1810 Eutaw Place—17

* Deceased.
§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

Gonzalez, Luis Felipe, Jr., 1103 Woodington Road—29
Goodman, Howard, 1513 N. Milton Avenue—13
Goodman, Jerome Edward, 809 Cathedral Street—1
Goodman, Julius H., 3400 E. Baltimore Street—24
Goodman, Louis E., 1211 Eutaw Place—17
Goodman, Sylvan Chauncey, 2202 Park Avenue—17
Goodwin, Georgina Y., 6704 Maxalea Drive—12
Gordon, Coral, 331 Tunbridge Road—12
Gordon, Harry H., Sinai Hospital—5
Gordy, Lyle L., 5106 Harford Road—14
Goresky, Carl Arthur, Baltimore City Hospitals—24
§Gorten, Martin K., University Hospital—1
§Gould, John Joseph, 14 N. East Avenue—24
Govatos, George, Medical Arts Building—1
Grabill, James R., 1945 W. Baltimore Street—23
§Graff, Thomas D., 1118 Bryn Mawr Road—10
Graham, R. Walter, Jr., Office of the Comptroller, 204 City Hall—2
Granoff, Hyman L., 2240 Eutaw Place—17
§Gray, Watson W., 1014 St. Paul Street—2
Graziano, Theodore J., 4019 Alameda—18
Greenberg, Sahler M., 3202 N. Hilton Street—16
Greenstein, George H., 819 Park Avenue—1
Greenwald, Leon, 1801 Eutaw Place—17
Greishman, Sheldon E., 4443 Clifton Road—16
Grempler, Walter E., 4513 Old Frederick Road—29
Grenzer, William H., 1520 E. 33rd Street—18
Grigoleit, Alfred W., 4801 Holder Avenue—14
Grimes, S. Butler, 100 W. University Parkway—10
Grob, David, 4017 Elderon Avenue—15
Grose, William E., 1201 N. Calvert Street—2
Gross, Joseph B., 6911 Park Heights Avenue—15
Grossman, I. Karl, 1527 E. North Avenue—13
Grott, Harold A., 8100 Harford Road—14
§Grow, John Lockwood, 2 E. Read Street—2
Grubb, Wilson, 4 E. 33rd Street—18
Grumbine, Francis L., 411 N. Chapelgate Lane—29
Gubnitsky, Albert, 5415 Park Heights Avenue—15
§Guerin, Paul Frederick, 700 Fleet Street—2
Guido, Angelina, 14 W. Mt. Vernon Place—1
Gundersheimer, Herbert N., Cordova Apartments—17
§Gundry, Lewis P., Relay 27, Md.
Gundry, Rachel K., Athol, Catonsville—29
§Gutman, Isaac, 817 St. Paul Street—2
Guttmacher, Carola B., 819 Park Avenue—1
Guttmacher, Manfred S., 819 Park Avenue—1
Haase, Frederick Robert, The Latrobe—2
Haase, John Henry, 2926 E. Cold Spring Lane—14
Hachtel, Frank W., 122 W. Lafayette Avenue—17
Hackett, Paul R., 7926 Springway—4
Hahn, Richard D., 1422 Park Avenue—17
§Haines, John S., 11 E. Chase Street—2
Hall, Arthur Thomas, Jr., 2 E. Read Street—2
Hamberry, Leonard G., 1200 E. 36th Street—18
§Hamburger, Louis P., 1001 St. Paul Street—2
Hamburger, Louis P., Jr., 1001 St. Paul Street—2
Hammond, Anthony F., Jr., 3205 Walbrook Avenue—16
Handelsman, Jacob Charles, 1112 N. Calvert Street—2
Hankin, Samuel J., 3479 Liberty Parkway—22
Harbold, Harold Valentine, 4706 Harford Road—14
Hardy, Janet B., Glenarm, Md.
Harmon, Louis E., 2224 Madison Avenue—17
Harper, Paul, 615 N. Wolfe Street—5
Harris, Bernard, Jr., 1200 McCulloh Street—17
Harris, S. Elliott, 8100 Harford Road—14
§Harrison, Clinton R., 1118 St. Paul Street—2
Harrison, Edmund P. H., 2903 N. Charles Street—18
Harrison, Harold E., 3001 Fordney Lane—7
Hart, Jeremiah A., 311 W. 31st Street—11
Hartman, John Frederick, 4 N. Lakewood Avenue—24
Hartman, Oscar, 1801 Eutaw Place—17
Hartz, Jerome, 11 E. Chase Street—2
Harvey, A. McGehee, Johns Hopkins Hospital—5
Harvey, John Collins, 410 Northway—18
Haskins, Arthur L., University Hospital—1
§Haws, John March, 1201 N. Calvert Street—2
§Hayleck, Mary L., 4401 Underwood Road—18
Hayward, Eugene H., 13 E. Eager Street—2
Healy, Robert F., Medical Arts Building—1
Hebb, Donald B., Cockeysville, Md.
§Hebb, John H., 901 Cathedral Street—1
Hecker, Erwin, 3668 Forest Garden Avenue—7
Heghinian, Jeannette R., 2212 South Road—9
§Helfrich, William G., 5006 Roland Avenue—10
§Helrich, Martin, Dept. of Anesthesiology, University Hospital—1
Hendry, Marjorie H., Union Memorial Hospital—18
Herbert, Thomas Franklyn, 46 Church Road, Ellicott City
§Herman, N. B., 1041 St. Paul Street—2
Herold, Paul Garmer, 1222 Walters Avenue—12
§Hersperger, W. Grafton, 12 E. 33rd Street—18
§Higgins, I. Bradshaw, 2243 Madison Avenue—17
§Highstein, Benjamin, 121 S. Highland Avenue—24

§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.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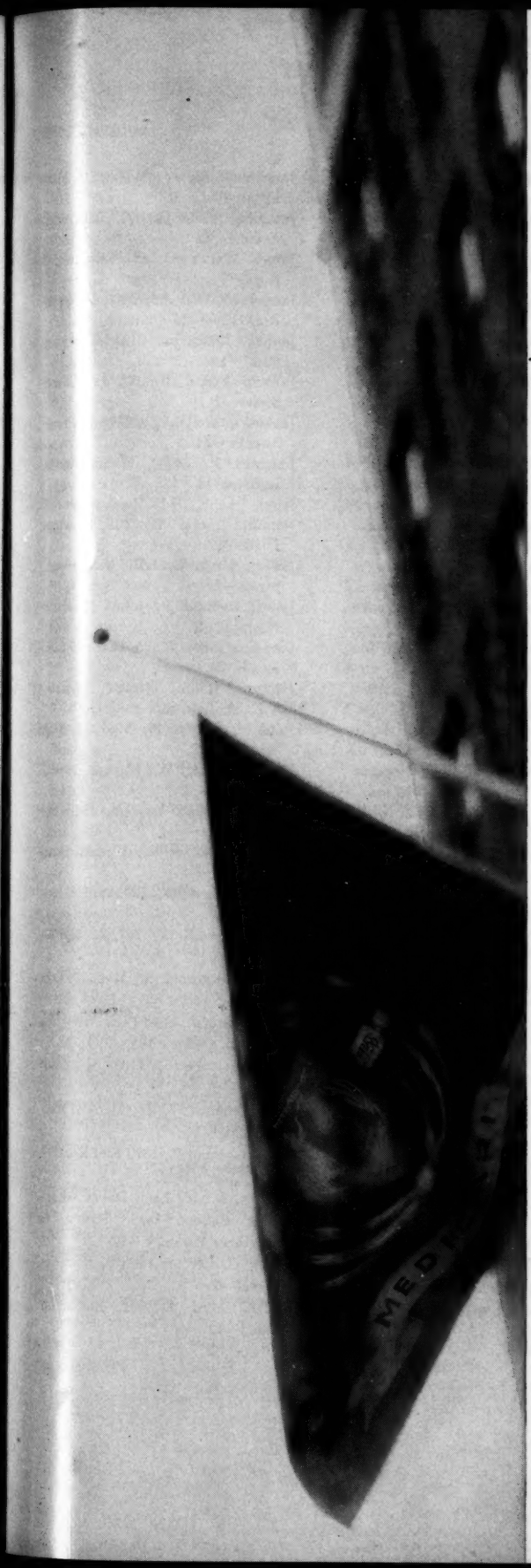

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Himelfarb, Albert J., 3501 St. Paul Street—18
§Hirschfeld, John H., 6919 Harford Road—14
Hitzrot, James M., II, 1705 Sherwood Avenue—24
Hobelmann, Charles F., 21 W. 27th Street—18
Hoeprich, Paul D., Department of Medicine, Johns Hopkins Hospital—5
§Hoffman, Elmer, 914 N. Charles Street—1
Hoffman, Reuben, 3602 Forest Park Avenue—16
§Hogan, John F., 2 E. Read Street—2
§Hogan, John F., Jr., 2 E. Read Street—2
Hollander, David H., 5514 Kemper Road—10
Holzworth, Dorothy C., 9207 Satyr Hill Road—34
Hood, Bowman J., 317 Broxton Road—12
Hooker, Donald, 204 Kemble Road —18
Hooper, Joseph H., Jr., U.S.N., U.S.S. Edisto, A.G.B. 2, % F.P.O., New York, N. Y.
Hooper, Z. Vance, 3534 Ellerslie Avenue—18
Hoover, Richard E., 14 W. Mt. Vernon Place—1
Hope, Daniel, Jr., Braewood S. Rolling Road—28
Hopf, Edward W., 355 S. Cornwall Street—24
§Hopkins, H. Hanford, 1201 N. Calvert Street—2
§Hopkins, James E. T., 205 W. Lanvale Street—17
Hopkins, John Vernon, 129 E. Redwood Street—2
Horine, Cyrus F., Medical Arts Building—1
§Horning, Edward Douglas, 18 W. Franklin Street—1
§Horton, William Preisz, 115 Witherspoon Road—12
Houpt, William P., 4920 Frankford Avenue—6
§Houska, Henry John, 333 S. East Avenue—24
Howard, John Eager, Johns Hopkins Hospital—5
§Howard, John Tilden, 12 E. Eager Street—2
Huffer, Virginia, University Hospital—1
Hughes, James L., USNR, Cherry Pt. Station Hospital, 2nd Marine Air Wing, Cherry Point, N. C.
Hulfish, Barbara, Neurology Division, University Hospital—1
§Hull, Harry Clay, 521 Medical Arts Building—1
Hulla, Jaroslav, 2214 E. Fayette Street—31
§Hundley, J. Mason, Jr., Medical Arts Building—1
*Hunner, Guy L., Charles & 34th Streets—18
Hurwitz, Abraham B., 3403 Garrison Boulevard—15
Hurwitz, Chester E., 2218 Eutaw Place—17
Hutchins, Amos Francis, Joyce Lane, Box 278, Arnold 2, Md.
§Hyatt, Irvin, 6107 Hopeton Avenue—15
Hyde, H. C., 1100 E. North Avenue—2
§Hyman, Calvin, 2500 Eutaw Place—17
§Hyman, Nathan B., 1805 Eutaw Place—17
Iliff, Charles Edwin, 14 W. Mt. Vernon Place—1
§Imboden, John Baskerville, 1010 Malvern Avenue—4
§Ingalls, George Sam, 703 Cathedral Street—1
§Insley, James K., Jr., 2200 Mayfield Avenue—13
Ireland, Robert W., Baltimore City Hospitals—24
Isaacs, Benjamin H., 1261 E. Belvedere Avenue—12
Iwantsch, Alfred E., 4234th U.S.A.F. Hospital, MacDill A.F.B., Fla.
Jackson, Dudley Pennington, Johns Hopkins Hospital—5
Jackson, Robert L., 600 North Arlington Avenue—17
Jacobs, Louis Llewellyn, 1701 Eutaw Place—17
Jacobson, Meyer William, 2310 Eutaw Place—17
Jahrreiss, Walter O., 4212 Patterson Avenue—15
James, Walter E., 1544 Kirkwood Road—7
Jandorf, R. Donald, 6405 Western Run Drive—15
Janney, Nathan, 7101 Harford Road—14
Jarrett, Edwin B., 11 E. Chase Street—2
Jaworski, Melvin J., 2711 Eastern Avenue—24
Jennings, F. Leslie, Medical Arts Building—1
Jeppi, Joseph, 10 E. Read Street—2
*Jerardi, Joseph V., 107 Armagh Drive—12
§Jewett, Hugh J., 1201 N. Calvert Street—2
Johns, Richard J., Johns Hopkins Hospital—5
Johnson, Elliot W., 3432 Frederick Road—29
Johnson, John Triplett Haxall, 4 E. Madison Street—2
§Johnson, Marius P., Medical Arts Building—1
Johnson, Robert W., Jr., 4 E. Madison Street—2
Johnson, Robert W., III, 1014 St. Paul Street—2
Johnson, William R., Medical Arts Building—1
Jones, Benjamin F., 1201 N. Calvert Street—2
Jones, Everett D., 101 E. Biddle Street—2
Jones, Georgeanna S., Medical Arts Building—1
Jones, Grace G., Park Heights Avenue, Owings Mills P.O., Md.
Jones, H. Alvan, 1107 St. Paul Street—2
Jones, Howard W., Jr., Medical Arts Building—1
Jones, Norman P., 1079 Elm Road—27
Josephs, David, Loch Raven Shopping Center, Loch Raven & Northern Parkway—12
Joslin, C. Loring, 1800 N. Charles Street—1
§Kadan, Ferd E., 23 Buchanan Road—12

* Deceased.
§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

Kader, Benjamin, 6901 Fieldcrest Road—15
Kahan, E. Louis, 2115 Sulgrove Avenue—9
§Kaine, Harry Cardinal, Jr., 730 Reservoir Street—17
Kallins, Edward S., 4300 Liberty Heights Avenue—7
§Kaltreider, D. Frank, 1526 Northwick Road—18
Kammer, William H., Jr., 612 W. 40th Street—11
Kane, Harry F., 313 Southwind—4
Kaplan, Eugene, 6304 Shelrick Drive—9
Kaplan, Irvin B., 129 S. Broadway—31
Kaplan, Isadore, 3314 Marnat Road—8
Kappelman, Melvin Daniel, 817 St. Paul Street—2
§Kardash, Theodore, Medical Arts Building—1
§Karfgin, Arthur, 1532 Havenwood Road—18
§Karfgin, Walter E., 4331 Harford Road—14
Karns, Clyde F., Medical Arts Building—1
Karns, James R., 700 Cathedral Street—1
Kassel, Leon E., 6839 Westridge Road—7
Kates, Harry F., 517 Scott Street—30
Katz, Sydney S., 700 Fleet Street—2
Katzenberger, James W., 4123 Frederick Avenue—29
Kayser, Fayne A., Medical Arts Building—1
Keller, Charles J., 222 W. Monument Street—1
Kelly, Alma Braun, 4812 Lindsay Road—29
Kelly, John Edward, Jr., University Hospital—1
§Kelly, Vernon C., 7215 York Road—12
Kemick, Irvin B., 3736 Towanda Avenue—15
§Kemler, Joseph I., 2230 Park Avenue—17
Kemp, Katherine V., 722 Stamford Road—29
Kennedy, John Joseph, 5800 Northwood Drive—12
§Keown, Lauriston L., 431 E. Lake Avenue—12
Kerman, Edward F., 3700 Liberty Heights Avenue—15
§Kern, Howard M., Esplanade Apartments—17
Kerr, Charles M., 6801 Belair Road—6
Ketron, Lloyd W., 1125 St. Paul Street—2
§Kiefer, Lester, 1115 Granville Road—7
Kieffer, Richard F., Jr., 5000 Springlake Way—12
Kiel, August, Jr., 2 W. Read Street—1
§Kilby, Walter L., Medical Arts Building—1
§Kimberly, Robert C., 802 Cathedral Street—1
§Kimmel, Louis E., Jr., 925 Lenton Avenue—12
Kimzey, Fritz J., 2700 Harford Road—18
King, John T., 1210 Eutaw Place—17
King, Joseph D. B., 1210 Eutaw Place—17
King, R. Taylor, 24 E. Eager Street—2
Kirby, Frank J., 1138 Obispo Avenue, Coral Gables, Fla.
§Kirkpatrick, Crawford N., Jr., 6 E. Eager Street—2
Kirsh, Milton B., 2320 Eutaw Place—17
Kitlowski, Edward A., 3301 N. Charles Street—18
Kleiman, Allen, 1115 N. Calvert Street—2
Kleiman, Bernard S., 1113 N. Calvert Street—2
Kleiman, Norman R., 3803 Edmondson Avenue—29
Klein, Donald Frederick, Baltimore City Hospitals—24
Klein, S. Wayne, 511 Castle Drive—12
§Klemkowski, Irvin P., 2 E. Read Street—2
§Klimes, Louis F., 2623 E. Monument Street—5
§Klinefelter, Harry F., Jr., 1101 N. Calvert Street—2
Klotz, Ben, 817 St. Paul Street—2
Knell, Joseph A., Jr., 6131 Dunroming Road—12
Knipp, George A., 4116 Edmondson Avenue—29
Knipp, Harry Lester, 4116 Edmondson Avenue—29
Knox, J. H. Mason, III, 600 W. Belvedere Avenue—10
§Kochman, Leon A., 3508 Denison Road—15
§Kohlerman, Nicholas J., The Latrobe Apartments—2
Kohlmeyer, Werner A., 719 W. University Parkway—10
Kohn, Walter, 102 E. Fort Avenue—30
§Kolman, Lester N., 3700 Park Heights Avenue—15
§Kolodner, Louis J., 2502 Eutaw Place—17
§Koontz, Amos R., 1014 St. Paul Street—2
§Kotz, Leonard, 6819 Reisterstown Road—15
Kourey, Salem W., 4404 Bedford Place—18
Krager, John M., 1658 Ramblewood Road—12
Krause, Louis, 11 E. Chase Street—2
Kravitz, Sheldon C., 2415 Kenoak Road—9
§Krejci, John J., 2 W. Read Street—1
§Kremen, Abraham, 2355 Eutaw Place—17
§Krepp, Martin W., Jr., 1114 St. Paul Street—2
Kress, Milton B., Medical Arts Building—1
Krevans, Julius R., 5720 Uffington Road—9
Krieg, Edward L. J., 510 N. Chapel Gate Lane—29
Krulevitz, Kenneth, 400 N. Hilton Street—29
Krumrein, Louis F., 722 N. Kenwood Avenue—5
Kudirka, Justinas, 2151 Wilkens Avenue—23
§Kuehn, Frank G., 1511 Cranwell Road, Lutherville, Md.
Kumkowski, Andrew, 2529 Eastern Avenue—24
Kurland, Albert A., 6207 Winner Avenue—15
Kyper, Fred T., 827 Park Avenue—1
Lachman, Harry, 2322 Callow Avenue—17
LaForest, Albert L., 822 N. Bond Street—5
§Lally, Leo A., 3517 Edmondson Avenue—29
Lambros, Byruth L., 213 Mallow Hill Road—29
§Landmesser, Walter Earl, Jr., 218 Medical Arts Building—1

§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

§Lang, Milton Charles, 2117 Belair Road—13
Langenfelder, Henry E., 104 W. Madison Street—1
Langworthy, Orthello Richardson, 800 Malvern Avenue—4
Lapp, Herbert Walter, 4804 Frederick Avenue—29
Lasell, Eldridge L., 16 E. Biddle Street—2
Laukaitis, Joseph C., 679 Washington Boulevard—30
Lavy, Louis T., 1844 W. North Avenue—17
Lawrence, Carteret, Gibson Island, Md.
Leach, C. Edward, 14 E. Eager Street—2
Lebo, Lester, 1801 Eutaw Place—17
§Lederman, Edward I., 4504 Maine Avenue—7
Le Doux, Clarence W., 3023 Eastern Avenue—24
§Lee, Benjamin B., 1205 Ten Oaks Road—27
Lee, Lionel Boon Quee, Union Memorial Hospital—18
Lee, Thora W., Balti more City Hospitals—24
Leeper, Lucius W., 1136 Poplar Grove Street—16
Legge, John E., 700 Cathedral Street—1
Legum, Samuel, 1261 E. North Avenue—2
Leipold, Ernest A., Jr., Union Memorial Hospital—18
Leitz, T. Frederick, Temple Garden Apartments—17
Lemmert, William A., 4242 Parkton Street—29
Lenhard, Raymond E., 1107 St. Paul Street—2
Leong, James T., MC, U. S. Army Hospital, Ft. Devens, Mass.
§Lerner, Philip F., 1111 St. Paul Street—2
Leslie, Franklin Earl, 18 Charlcote Place—18
Levi, Ernest, 817 St. Paul Street—2
Levi, J. Elliot, 1020 St. Paul Street—2
Levickas, Herbert J., 5305 East Drive—27
Levin, H. Edmund, 3400 Hilton Road—15
Levin, Manuel, 4818 Reisterstown Road—15
§Levin, Milton, 2240 Eutaw Place—17
Levin, Morris Benjamin, 218 E. University Parkway—18
Levin, Norman, 3503 Milford Avenue—7
Levine, Hilbert M., 403 Milford Mill Road—8
Levine, Stuart C., 809 Cathedral Street—1
§Levy, Charles S., Medical Arts Building—1
Levy, Isidore I., 3530 Hilton Road—15
§Levy, Kurt, 3103 N. Charles Street—18
Lewis, J. L., Jr., 11 E. Chase Street—2
§Lewison, Edward F., 1020 St. Paul Street—2
Liang, Ping Y., 700 Cathedral Street—1
Liberles, Lucille, 1739 Eutaw Place—17
§Liberto, Joseph R., 3508 Bank Street—24
Lichtenstein, Gemma M., 6731 Queens Ferry Road—12
Lieberman, Alfred T., 29 E. Mt. Vernon Place—2
Lilienfeld, Samuel, 2926 E. Cold Spring Lane—14
Linas, Sidney, 1211 Eutaw Place—17
Linden, Harry, 14 S. Broadway—31
Lindenberg, Richard, 700 Fleet Street—2
Li Pira, Joseph Francis, 8400 Loch Raven Boulevard—4
Lippy, George D., 206 Kemble Road—18
§Lisansky, Ephriam T., 3210 Liberty Heights Avenue—15
Lister, Leonard M., 2500 Eutaw Place—17
Liteanu, Michael, 2713 Geartner Road—9
Little, Luther E., 10 W. Madison Street—1
§Liu, Sze-Jiu, United States Army Hospital, Ft. Leonard Wood, Mo.
Liu, Wei-Chi, Department of Anesthesia, Johns Hopkins Hospital—5
Livingston, Samuel, 1039 St. Paul Street—2
Loch, Walter E., 1039 North Calvert Street—2
Lockard, James Douglas, 802 Cathedral Street—1
Loker, F. Ford, 1120 St. Paul Street—2
§Long, John Herman, 11 E. Chase Street—2
Long, W. Newton, Jr., 3332 St. Paul Street—18
Longley, George H., 203 W. Lanvale Street—17
Love, Thomas A., 3701 Duvall Avenue—16
Love, William S., 1214 N. Calvert Street—2
Lovitt, William V., Jr., 1106 Sleepy Dell Court—4
Lowitz, Irving Robert, 6021 Highgate Drive—15
Lumpkin, Morgan Leroy, 914 N. Charles Street—1
§Lumpkin, Wm. Randolph, 618 Valley Lane—4
Lupo, Deonis M., 11 E. Chase Street—2
Luttrell, Charles Nelson, Jr., 3114 Moravia Road—14
§Lyden, Robert James, 601 Middlesex Road—21
§Lynn, William D., 5002 St. Albans Way—12
§Lyon, James A., Jr., Radiology Department, University Hospital—1
Lyons, William B., Paisley Road, Gibson Island, Md.
McAfee, John G., 608 Windwood Road—12
McCarthy, Charlotte, 2919 St. Paul Street—18
McCarty, H. D., 37 W. Preston Street—1
McCauley, A. Franklin, 302 E. 33rd Street—18
§McClafferty, William J., 315 St. Dunstans Road—12
McClary, Allan R., 411 Alabama Road—4
McCluer, Shirley M., Montebello State Hospital—18
McCosh, James N., 8404 Bellona Lane—4
McDonald, George, 844 N. Carey Street—17
McDonnell, Edmond J., 4 E. Madison Street—2
McElwain, Howard B., 31 E. North Avenue—2

§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

McFadden, Robert B., The Latrobe Building, Charles & Read Streets —2
McGrath, Dennis Joseph, 8358 Loch Raven Boulevard—4
McIntyre, Patricia A., 6239 Falls Road—9
§McKay, John Nelson, 6014 Edmondson Avenue—28
McKenzie, W. Raymond, Medical Arts Building—1
McKinnon, George E., 3491 Highland Drive, Salt Lake City, Utah
McKusick, Victor A., Johns Hopkins Hospital—5
McLanahan, Samuel, 108 E. 33rd Street—18
McLean, George, Medical Arts Building—1
McLean, Ross L., Department of Medicine, Emory University, 69 Butler Street, S.E., Atlanta 3, Ga.
McNally, Hugh B., 1008 Winding Way—10
McQueen, J. Donald, Baltimore City Hospitals, Department Surgery, 4940 Eastern Avenue—24
Macek, Francis John, Jr., 309 Edsdale Road—29
MacGibbon, John B., MC, USNR, U. S. Naval Retraining Center, Portsmouth, N. H.
Machen, John W., 6331 Belair Road—6
Macht, Allan Harris, 3818½ Belle Avenue—15
Macht, David I., 6110 Biltmore Avenue—15
§Mack, H. Patterson, 3829 Arbutus Avenue—7
Mackowiak, Stephen C., 6714 Holabird Avenue—22
Macks, Isaac M., 3506 Liberty Heights Avenue—15
MacLaughlin, D. C., 4508 Edmondson Village—29
§MacLean, Angus L., 1201 N. Calvert Street—2
MacMinn, Charles C., Jr., 2911 E. Baltimore Street—24
Magladery, John William, Johns Hopkins Hospital—5
Magruder, William Wailes, 307 Broxton Road—12
Mahon, Robert Joseph, 2802 Moorgate Road—22
Mahoney, Florence I., Montebello State Hospital—18
Mandy, Arthur Jennings, Medical Arts Building—1
Mandy, Theodore E., Medical Arts Building, Cathedral & Read Streets—1
§Manieri, Frank V., 3503 Crossland Avenue—13
Mansberger, Arlie Roland, Jr., 3513 Sussex Road—7
§Mansdorfer, G. Bowers, 2937 N. Charles Street—18
§Mansfield, W. Kenneth, The Latrobe Building, 2 E. Read Street—2
Marandi, Kazem A., 15 E. Biddle Street—2
Marburg, Rudolf, 2 E. Read Street—2
§Marek, Charles B., 3300 The Alameda—18
Marine, David N., 1733 Bolton Street—17
Marino, Frank C., 1129 St. Paul Street—2
§Markley, Raymond Law, Medical Arts Building—1
Markowitz, Milton, 1027 N. Calvert Street—2
Marr, Ernest G., 516 Cathedral Street—1
Marr, William G., 10 E. Chase Street—2
Marriott, Henry J. L., 5003 Wetheredsville Road—7
*Marston, James G., 516 Cathedral Street—1
§Martin, Lay, 1201 N. Calvert Street—2
Maser, Louis R., 4335 Park Heights Avenue—15
Maseritz, I. H., Temple Garden Apartments, Cloverdale Road & Madison Avenue—17
Mason, Robert E., 9 E. Chase Street—2
Mass, Christian S., 413 Nottingham Road—29
Matchar, Joseph Charles, 4004 Liberty Heights Avenue—7
Maumenee, A. Edward, Johns Hopkins Hospital—5
§Mawhinney, Charles, Jr., Hospital for Women of Maryland—17
Maxson, Charles Walter, Point Pleasant, N. J.
May, Robert E., 1200 Woodbourne Avenue—12
May, William T., 2519 Eutaw Place—17
Mayer, Erwin E., The Esplanade—17
§Mays, Howard Brooks, 3301 N. Charles Street—18
Meath, James A., 8 Charlcote Place—18
§Mech, Karl F., 11 E. Chase Street—2
§Mendeloff, Albert I., Sinai Hospital—5
Menning, Joseph H., 101 W. Read Street—1
Meranski, Israel P., 3354 Dolfield Avenue—15
Merkel, Walter C., Union Memorial Hospital—18
Meyer, Eugene, III, 809 W. Lake Avenue—10
Michael, Arnold H., 2425 Hunt Drive—9
Michel, William, 1015 Poplar Grove Street—16
Michels, Joseph T., Apt. 5-A, 11 East Chase Street—2
Michelson, Elliott, 1801 Eutaw Place—17
Middleton, B. Martin, 319 Medical Arts Building—1
Middleton, Edmund Bishop, 3741 Beech Avenue—11
Milan, Albert Richard, 320 E. 33rd Street—18
Milan, Edward Fortune, 682 Washington Boulevard—30
Mildvan, Albert Samuel, Baltimore City Hospitals—24
Millea, William L., 3101 St. Paul Street—18
Miller, Benjamin, 2030 Wilkens Avenue—23
Miller, George H., A03077073, 3345th U.S.A.F. Hospital, Chanute A.F.B., Ill.
Miller, Harry A., 2452 Eutaw Place—17
Miller, Isaac, 1228 S. Charles Street—30
§Miller, Jacob M., 1613 E. Baltimore Street—31
Miller, James Patton, 804 Cathedral Street—1
§Miller, John Ernest, 719 Morningside Drive—4
Miller, John Harold, X-ray Department, Church Home and Hospital—31

* Deceased.
§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

§Miller, Joseph G., 107 W. Saratoga Street—1
Miller, Mitchell H., 600 W. Belvedere Avenue—10
Miller, Stanley, 914 N. Charles Street—1
Milnor, William R., 801 Malvern Avenue—4
§Mintzer, Donald W., 1922 E. Belvedere Avenue—14
Mirick, George S., Baltimore City Hospitals—24
Mitchell, George W., 2 W. University Parkway—18
§Mitchell, John A., 422 Medical Arts Building—1
§Molumphy, Paul Edward, 1561 Stonewood Road—12
Monninger, Arthur C., 800 E. North Avenue—2
Mooney, Albert Lee, 1701 Hartsdale Road—14
Moore, Alfred C., 2122 Broening Highway—24
Moore, James I., 11 E. Chase Street—2
*Moore, Joseph Earle, Medical Arts Building—1
Moore, Kirk, The Latrobe—2
Moore, Marcus W., Sr., 1371 N. Carey Street—17
Moores, J. Duer, 3105 Bel Air Road—13
Morgan, Russell H., Johns Hopkins Hospital—5
§Morgan, Zachariah R., 10 E. Eager Street—2
Morningstar, George L., A022319817 (MC), Flight Surgeon's Office Pope A.F.B., Ft. Bragg, N.C.
Morris, Frank K., 3913 Juniper Road—18
Morris, John D., 2 W. University Parkway—18
§Morrison, J. Huff, 707 Chumleigh Road—12
Morrison, Samuel, 11 E. Chase Street—2
§Morrison, Theodore H., 11 E. Chase Street—2
Mosberg, William H., Jr., 107 St. Johns Road—10
Moses, Benjamin B., 448 N. Luzerne Avenue—24
Moses, Bessie L., 519 Medical Arts Building—1
Mostwill, Ralph, 1805 Eutaw Place—17
Mueller, C. Herbert, Jr., Monkton P.O., Hereford, Md.
Mueller, Eugene Alexander, 1653 Waverly Way—12
Mueller, Paul Godfrey, 3750 Ellerslie Avenue—18
Muller, S. Edwin, 2 W. Read Street—1
Mulligan, E. James, 5600 Harford Road—14
Muncie, Wendell S., 11 E. Chase Street—2
Murgatroyd, George W., Jr., 1127 St. Paul Street—2
Murphy, Bernard William, 11 E. Chase Street—2
Murray, John Gardner, Jr., 3408 St. Paul Street—18
§Muse, Joseph E., Jr., 2725 N. Charles Street—18
Muse, William T., 2436 Washington Boulevard—30
Myerowitz, Joseph R., 5145 Park Heights Avenue—15
Myers, John A., 104 E. Biddle Street—2
§Myers, Joseph Carl, 1401 E. Coldspring Lane—12
Myers, Myron J., 2500 Eutaw Place—17
Myers, Philip, 2425 Eutaw Place—17
Nachlas, Marvin M., Sinai Hospital—5
*Nachlas, I. William, 819 Park Avenue—1
Nadolski, Florian P., 205 Hampton Road, Linthicum Heights, Md.
Nager, George T., The Johns Hopkins Hospital—5
Nagler, Richard, Baltimore City Hospitals—24
Naquin, Howard A., 14 W. Mt. Vernon Place—1
§Needle, Nathan E., 4215 Park Heights Avenue—15
§Nelson, Alfred T., 4526 Marble Hall Road—12
Nelson, James Wharton, 500 Club Lane—4
Nelson, Russell A., Johns Hopkins Hospital—5
Nesbitt, John A., Jr., 1118 St. Paul Street—2
§Neubauer, Imre, 936 Patapsco Avenue—25
Neustadt, John O., Johns Hopkins Hospital—5
§Niblett, Walter S., 4508 N. Charles Street—10
Nichols, Firmadge King, 4711 Roland Avenue—10
§Niermann, William A., 3506 N. Calvert Street—18
Nipkow, Hans, 5525 Belair Road—6
Nitowsky, Harold M., 3115 Bancroft Road—15
Norton, John Charles, Jr., 3603 Edmondson Avenue—29
Norwood, Vernon H., Church Home & Hospital—31
Novak, Edmund R., 26 E. Preston Street—2
Novak, Eduard, Medical Arts Building—1
Novey, Riva, 19 W. Cold Spring Lane—10
Nowak, Sigmund R., 408 S. Patterson Park Avenue—31
Noya, Joseph J., 604 Chapelgate Lane—29
§O'Connor, John A., 11 E. Chase Street—2
O'Dell, John C., 3800 Canterbury Road, Apt. E—18
O'Donovan, Charles, Jr., 3111 N. Charles Street—18
Ogden, Frank N., 2701 N. Calvert Street—18
§O'Hare, James S., 5003 Broadmoor Road—12
§O'Rourk, Thomas R., 104 W. Madison Street—1
Osborne, John C., 3122 Northern Parkway—14
§Ossman, Alfred G., Jr., 216 E. University Parkway—18
Otenasek, Frank J., 6 E. Eager Street—2
Owen, Arthur J., 1200 E. Belvedere Avenue—12
§Owen, John Keller, 104 W. Madison Street—1
Owens, Albert Henry, Jr., 540 Park Avenue—4
§Owings, James C., 18 W. Franklin Street—1
§Ozazewski, John Casimir, 1540 Oakridge Road—18
Pacienza, Frank A., 511-13 Medical Arts Building—1
§Padussis, Stephen K., 401-402 Medical Arts Building—1

* Deceased.
§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

Pahk, Elizabeth Y., 1653 Shadyside Road—18
Pair, James Mansfield, 400 N. Carrollton Avenue—23
Palese, John M., 2412 Pelham Avenue—13
Palmisano, Joseph Frank, 6014 Loch Raven Boulevard—12
Papastrat, Constantine J., Veterans Administration Hospital, Ft. Howard, Md.
Pardhoff, Merrill E., 1004 Reisterstown Road—8
Park, Edward A., 512 Pathology Building, Johns Hopkins Hospital—5
Parker, Robert T., 620 Wilton Road—4
Parker, William S., Bancroft Ct. Apts., 6506 Park Heights Avenue—15
Parsons, John W., 11 E. Chase Street—2
§Pass, I. Earl, 4001 Wilkens Avenue—29
Pats, Albert, 3026 St. Paul Street—18
Patt, Howard H., The Esplanade Apartments, 2519 Eutaw Place—17
Patten, David H., 108 W. Military Road, Hampton, Va.
Patton, Genieann P., 1120 St. Paul Street—2
Patz, Arnall, 1212 Eutaw Place—17
§Paulson, Moses, 11 E. Chase Street—2
Peake, Clarence W., 4508 Harford Road—14
Pearce, William F., 2105 N. Charles Street—18
Peck, John L., 5506 Lombardy Place—10
Pembroke, Richard H., Jr., 209 E. Biddle Street—2
Perilla, F. Robert, 4501 Wentworth Road—7
Perlman, Anthony, 1029 N. Calvert Street—2
§Pessagno, Daniel J., Medical Arts Building—1
Peters, H. Raymond, 1127 N. Calvert Street—2
Phelan, Patrick C., Jr., 2 Burnbrae Road—4
Phelps, Winthrop Morgan, 3038 St. Paul Street—18
Phillips, Otto C., 2225 Lake Avenue—13
§Pierce, Leslie Harrall, 700 Cathedral Street—1
§Pierpont, Ross Z., 111 W. Monument Street—1
Pierson, J. W., 1107 St. Paul Street—2
§Pincoffs, Maurice C., University Hospital—1
Pines, Samuel R., The Latrobe—2
Pinkney, Talmadge Hall, 2310 W. North Avenue—16
Platt, Marvin S., 2938 St. Paul Street—18
*Pleasants, J. Hall, 201 Longwood Road—10
Pleet, Jerome, 3717 Sequoia Avenue—15
Poland, Warren Saul, 4506 Bonner Road—16
§Polek, Melvin F., 3603 Belair Road—13
Polvogt, Leroy M., 1201 N. Calvert Street—2
Porter, Harry P., 210 Cedarcroft Road—12
Prager, Helmut, 1117 St. Paul Street—2
Prather, Perry F., 5203 Falls Road, Apt. 7—10
Primakoff, H. William, Emersonian Apartments—17
Proctor, Donald Frederick, 819 Park Avenue—1
§Proctor, Samuel E., 104 W. Madison Street—1
§Prout, Thaddeus Edmund, 703 Beaverbrook Road—12
Queen, J. Emmett, 4418 Norwood Road—18
Racusin, Nathan, 206 S. Gilmore Street—23
§Radman, H. Melvin, Esplanade Apartments, Eutaw Place & Brooks Lane—17
Raffel, William, 701 Cathedral Street—1
Ramapuram, George M., 4975 Benmore Avenue—15
Ramirez, Jose S., Baltimore City Hospitals—24
Ramirez, Rafael V., The Latrobe Apartments—2
Randolph, M. Elliott, 11 E. Chase Street—2
§Rangle, Raymond V., 2938 St. Paul Street—18
Raskin, Moses, 817 St. Paul Street—2
Rathbun, Howard K., Carroll Manor Road, Baldwin, Md.
Ratliff, Cliff, Jr., 4605 Edmondson Avenue—29
Ravitch, Mark M., Johns Hopkins Hospital—5
Ray, Uthman, Jr., 1224 McCulloh Street—17
Reckling, Ralph W., 3301 Powhatan Avenue—16
Reese, Fred M., 330 N. Charles Street—1
Reichel, Samuel M., V. A. Hospital, Minneapolis 17, Minn.
Reichelderfer, Thomas E., Laboratory of Infectious Diseases, National Institutes of Health, Bethesda 14, Md.
§Reifschneider, Charles, 104 W. Madison Street—1
Reifschneider, Herbert E., 104 W. Madison Street—1
Reimann, Dexter Leroy, 2504 Creighton Avenue—14
§Reiter, Robert A., 3408 Windsor Avenue—16
Renner, William F., 11 W. 29th Street—18
§Revell, Samuel T. R., Jr., University Hospital—1
§Rever, William Benjamin, Jr., 8100 Kirkwall Court—4
Rich, Benjamin S., Medical Arts Building—1
Richardson, Aubrey D., 8309 Thornton Road—4
§Richardson, Edward H., 3 Whitefield Road—10
Richardson, Edward H., Jr., 9 E. Chase Street—2
Richardson, Horace K., 11 E. Chase Street—2
Richter, Christian F., 1001 St. Paul Street—2
§Richter, Conrad L., 226 St. Dunstan's Road—12
Ridgely, Irwin O., 201 W. Madison Street—1
Rienhoff, William Francis, Jr., 1201 N. Calvert Street—2
Riley, Eugene John, 209 Cedarcroft Road—12

* Deceased.
§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

Riley, Richard Lord, 1901 Dixon Road—9
§Rinehart, Arthur Middleton, 4824 Keswick Road—10
Rizika, Stuart D., 3411 Rosedale Road—15
Roach, Thomas Edward, 514 Drury Lane—29
Robbins, Martin A., The Esplanade Apartments, 2519 Eutaw Place—17
Roberts, David P., 11 E. Chase Street—2
§Roberts, George Allen, 16835 Patton Avenue, Detroit 19, Michigan
Robertson, J. Clagett, Sr., 117 S. Broadway—31
Robinson, Aaron, 1817 Eutaw Place—17
Robinson, Harry M., 106 E. Chase Street—2
§Robinson, Harry M., Jr., 1209 St. Paul Street—2
Robinson, Kent E., The Latrobe Building—2
Robinson, Robert Alexander, 314 Broxton Road—12
Robinson, Raymond C. V., 11 Murray Hill Circle—12
Rochberg, Samuel, 2202 W. Rogers Avenue—15
Roetling, Carl P., 1326 W. Lombard Street—23
Rogers, H. L., 101 E. Preston Street—2
Roman, Paul W., 1810 Eutaw Place—17
Rombro, Marvin Jay, 2409 W. Rogers Avenue—9
§Rosen, Harold, 1101 N. Calvert Street—2
Rosen, Israel, 2413 E. Monument Street—5
Rosendorf, Stanley B., 222 W. Lafayette Avenue—17
Rosenfeld, Morris, 3921 Pinkney Road—15
Rosenthal, Gilbert W., 4009 Liberty Heights Avenue—7
Rosenthal, Howard Nathaniel, 4580 Derby Manor Drive—15
Rosenthal, Melvin S., Baltimore City Hospitals—24
Rosin, John David, 1010 St. Paul Street—2
Ross, Richard S., Johns Hopkins Hospital—5
Rossberg, Clyde Arthur, 2436 Washington Boulevard—30
Rossello, Salvador, 4508 Edmondson Avenue—29
Rothholz, Alma S., 822 Belgian Avenue, Apt. 1-C—18
Rowland, William Marshall, 5502 Huntley Square—10
Rubin, Samuel, 5915 Park Heights Avenue—15
§Rubin, Samuel, 203 Patapsco Avenue—25
Rubin, Seymour H., 3132 Harford Road—18
Rubinstein, Hyman S., 2349 Eutaw Place—17
Rudin, Louis N., 5901 Ayleshire Road—12
Rudman, Gilbert E., 2517 W. Baltimore Street—23
Rudo, Alvin D., 2500 Eutaw Place—17
Russell, Thomas Edgie, Jr., 3901 N. Charles Street—18
§Russo, James, 829 Kingston Road—12
Rutledge, Benjamin H., 18 E. Eager Street—2
§Ruzicka, F. Fred, 800 N. Patterson Park Avenue—5
§Rysanek, Emil J., Strong Memorial Hospital, Rochester, N. Y.
Rysanek, William J., Sr., 801 N. Kenwood Avenue—5
Rysanek, William James, Jr., 1013 N. Calvert Street—2
Sabiston, David C., Jr., Dept. of Surgery, Johns Hopkins Hospital—5
§Sachs, Louis, Marlborough Apartments—17
Sacks, Milton S., University Hospital—1
Safar, Peter, 4716 Meise Drive—6
Salik, Julian O., 3602 Clarinth Road—15
Sanderson, John W., 1714 N. Caroline Street—13
Sandler, Robert, 513 N. Charles Street—1
Sardo, Robert S., 303 Woodbourne Avenue—12
Sarubin, Benjamin, 2031 Eutaw Place—17
Sauber, Irvin, 7300 Park Heights Avenue—8
§Saunders, L. W., 216 Goodale Road—1
§Savage, John Edward, 811 Boyce Avenue—4
Sawyer, George J., Jr., 4808 Harford Road—14
Sawyer, William H., Jr., 4928 West Hills Road—29
Saylor, Lloyd E., 3902 Greenmount Avenue—18
§Sborofsky, Isadore, 4212 Oakford Avenue—15
§Scagnetti, Albert, 1729 W. Lombard Street—23
§Scarborough, Clarence P., Jr., 212 W. Madison Street—1
Schaefer, John F., 401 Random Road—29
*Schaefer, Otto, 920 St. Paul Street—2
Schaffer, Alexander J., 1027 N. Calvert Street—2
Schapiro, Abraham, 2028 Eutaw Place—17
Schapiro, William B., 3335 Clarks Lane—15
Schenker, Paul, 2424 Eutaw Place—17
Scher, Ernest, 2500 Eutaw Place—17
Scher, Isadore, 2502 Eutaw Place—17
Scherlis, Irving, 3501 Overbrook Road—8
§Scherlis, Leonard, University Hospital—1
Scherlis, Sidney, 11 E. Chase Street—2
Scheurich, John A., 1337 S. Charles Street—30
Scheye, Henry W., 3921 Edmondson Avenue—29
Schiff, Hyman, 4023 Fallstaff Road—15
Schilling, Albert, 3610 Marmon Avenue—7
§Schimunek, Emmanuel, 842 S. East Avenue—24
Schnaper, Nathan, 1214 N. Calvert Street—2
Schnaufer, Louise, 4514 N. Charles Street—10
§Schnitzer, D. Eugene, 3904 S. Hanover Street—25
Schoenrich, Edyth Hull, 1402 Boyce Avenue—4
Scholz, Roy O., 11 E. Chase Street—2
§Schonfeld, Paul, 2301 Annapolis Road—30

* Deceased.
§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

Schreiber, M. B., 3506 Ellamont Road—15
Schultz, Kathryn L., 2023 Cedar Circle Drive—28
Schultz, Robert B., Department of Pathology, 31 S. Greene Street, University Hospital—1
Schultze, Gunter, 4 B, Beach Drive—20
Schuman, William, 1716 Eutaw Place—17
Schuster, Gerald David, 4511 Fairview Avenue—16
Schwartz, Benson C., 6305 The Alameda—12
Schwartz, Daniel J., 2320 Eutaw Place—17
§Schwartz, Theodore A., 834 Park Avenue—1
Scott, Eleanor, 1014 St. Paul Street—2
Scott, Harry B., 1112 St. Paul Street—2
§Scott, John M., 8 Longwood Road—10
Scott, William Wallace, 7700 Riderhill Road—4
Seebert, Calbert Trent, 1114 Ramblewood Road—12
Seegar, J. King B. E., Jr., 112 Elmhurst Road—12
§Seidel, Henry M., 1401 Reisterstown Road—8
Seidel, Herman, 2404 Eutaw Place—17
Seligman, Arnold M., Sinai Hospital—5
Serra, Lawrence M., 11 E. Chase Street—2
§Settle, William B., 126 Homeland Avenue—12
Sexton, Carlton Lasley, 819 Park Avenue—1
Shackelford, Richard T., 18 E. Eager Street—2
Shackman, Albert B., 705-6 Medical Arts Building—1
Shamer, Maurice Emory, 3300 W. North Avenue—16
§Shanahan, Daniel S., 1945 W. Baltimore Street—23
Shannon, George E., 820 Medical Arts Building—1
§Shapiro, Albert, 1109 N. Calvert Street—2
Shapiro, Jerome E., 3405 Forest Park Avenue—16
Shapiro, Morton Walter, 3110 Sumter Avenue—15
§Sharfatz, George, 5443 Park Heights Avenue—15
Sharp, Nathaniel, 6101 Eastcliff Drive—9
Sharrett, John O., University Hospital—1
§Shaw, Charles E., 5801 Loch Raven Boulevard—12
Shell, James H., Jr., Medical Arts Building—1
Sheppard, Amelia Link, 2211 Lake Avenue—13
§Sheppard, Henry, 922 W. University Parkway—10
Sheppard, Robert C., Medical Arts Building—1
Shepperd, J. Douglass, 604 N. Fulton Avenue—17
Sherman, Jerome, 2502 Eutaw Place—17
Sherman, Solomon, 2424 Eutaw Place—17
Shernan, Harry Donald, 2500 Eutaw Place—17
Sherry, Milton, 11 E. Chase Street—2
Shervington, E. Walter, 2301 Harlem Avenue—16
Shiling, Moses Samuel, 2500 Eutaw Place—17
Shimanek, Lawrence Joseph, 803 South Wind Court—4
§Shipley, E. Roderick, 618 Medical Arts Building—1
Shochat, Albert J., 4111 Liberty Heights Avenue—7
Shochet, Bernard R., 3612 Telmar Road—7
Shulman, Alfred J., The Latrobe Building—2
Shulman, Lawrence E., Johns Hopkins Hospital—5
§Shulman, Leon M., 1214 N. Calvert Street—2
Siegel, Isadore A., 6400 Park Heights Avenue—15
Silberman, David, Esplanade Apartments, 2519 Eutaw Place—17
Silver, A. A., Temple Garden Apartments—17
Sindelar, Joseph Basil, 422 Medical Arts Building—1
§Sindler, Joseph, 829 Lake Drive, J. 2. Alhambra Apartments—17
Sindler, Richard A., A03044985, 620th USAF Hospital, APO 74, San Francisco, Cal.
Singewald, A. G., 1613 E. North Avenue—13
Singewald, Martin L., 11 E. Chase Street—2
Singleton, Robert T., 1527 Langford Road—7
Bourdeau-Sisco, P. S., 2500 Garrison Boulevard—16
§Siscovick, Milton, 1429 W. Fayette Street—23
Siver, Robert H., 3105 N. Charles Street—18
§Siwinski, Arthur G., 15 E. Biddle Street—2
§Skloven, Joseph, 7122 Harford Road—14
*Slack, Harry R., Jr., 8 E. Bishop's Road—18
Slasman, William Howry, Jr., 111 Stanmore Road—12
Small, Mary L., 16 W. Read Street—1
Smelser, Rennert M., 11 E. Chase Street—2
Smink, Claud, St. Michaels, Md.
Smith, D. C. Wharton, 2 Wyndhurst Avenue—10
Smith, Edward P., 920 St. Paul Street—2
Smith, Ernest Wendell, 238 Brandon Road—12
Smith, Frank R., Jr., 623 W. University Parkway—10
§Smith, Fred B., 2 W. University Parkway—18
§Smith, Harry B., 801 Stoneleigh Road—12
§Smith, Howard Chandler, Medical Arts Building—1
Smith, James Edgar, II, 714 Park Avenue—1
§Smith, John Prinz, Loch Raven Boulevard & Northern Parkway—12
Smith, Joseph Lawton, Wilmer Institute, Johns Hopkins Hospital—5
Smith, Lex Burke, 1527 Wadsworth Way—12
Smith, Olive Cushing, 11 E. Chase Street, Suite 8 E—2
Smith, Ruby A., 513 N. Charles Street—1
Smith, Sol, 2500 Eutaw Place—17

* Deceased.
§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

Smith, Vernon M., 1526 York Road, Lutherville, Md.
Smith, Wm. H., 3429 Chestnut Avenue—11
Smith, Winford H., 100 W. University Parkway—10
§Snyder, Jerome, 11 E. Chase Street—2
Snyder, Nathan, 1200 St. Paul Street—2
*Snyder, Samuel, 1634 E. Baltimore Street—31
Sodaro, Manuel, 4624 York Road—12
Sokol, Liebe Deborah, ℅ Hospital of University of Pennsylvania, 13th & Spruce Streets, Philadelphia 4, Pa.
§Sollod, Aaron C., 707 E. Fort Avenue—30
Solomon, David M., 6601 Baythorne Road—9
Solomon, Robert D., 3204 Dorchester Road—15
Solowiej, Wladimir, 2811 Eastern Avenue—24
Sondheimer, A. Adler, Esplanade Apartments—17
Southwick, Wayne O., Johns Hopkins Hospital—5
Spear, Irving J., 928 N. Charles Street—1
Speed, William George, III, 11 E. Chase Street—2
Spence, John Morland, 2903 N. Charles Street—18
Spencer, Frank Cole, Johns Hopkins Hospital—5
§Spicer, William Sidney, Jr., 1635 Stonewood Road—12
§Spiegelman, Henry L., 638 Regester Avenue—12
Spier, Andrew Allen, 4408 Loch Raven Boulevard—18
Spitzberg, Randolph Howard, 5329 Reisterstown Road—15
Spurling, Carroll L., University Hospital—1
Stacy, Theodore E., Jr., Box 44, AA, R.F.D. 1, Phoenix, Md.
Stafford, Edward S., 11 E. Chase Street—2
Stambler, Alvin A., 6941 Reisterstown Road—15
Stebbins, Ernest L., 615 North Wolfe Street; School of Hygiene, Johns Hopkins Hospital—5
§Stedem, Anthony F. A., Jr., 11 E. Chase Street—2
§Steinbach, Stanley R., 3334 Dolfield Avenue—15
§Steinberg, Morris W., 410 N. Hilton Street—29
Steinberg, Murray, 2305 Hanway Road—9
Steiner, Albert, 1213 Eutaw Place—17
§Stevens, Leland B., 3400 Erdman Avenue—13
Stewart, Charles Wilbur, 6 E. Read Street—2
§Stewart, Edwin H., Jr., 618 Medical Arts Building—1
Stichel, Frederick L., Jr., 4580 Edmondson Avenue—29
Stickney, G. L., The Latrobe—2
Stifler, Jean Rose, Maryland State Department of Health, 2411 N. Charles Street—18
Stifler, William C., Jr., 3301 N. Charles Street—18
Stiles, Cleo D., Jr., Medical Arts Building—1
Stinson, Edward, Jr., 18 E. Eager Street—2
Stoler, Malcolm W., 3324 Dolefield Avenue—15
§Stone, Douglas H., 2921 St. Paul Street—18
Stone, Harvey Brinton, 203 Westway, Kernewood—12
§Stone, William S., Dean, University of Maryland School of Medicine, 522 W. Lombard Street—1
§Stout, Merrell L., Warrington Apartments, 3908 N. Charles Street—18
§Strahan, John Franklin, 1365 Kitmore Road—12
Straus, Donald, 611 N. Caroline Street—5
Styrt, Jerome, The Latrobe—2
Suarez-Murias, Edward L., 11 E. Chase Street—2
Sullivan, Maurice, 11 E. Chase Street—2
§Sullivan, Sullins G., 1129 St. Paul Street—2
Sullivan, William J., 11 E. Chase Street—2
Sultan, Louise U., 307 Woodlawn Road—10
Summers, Henry G., 300 Church Street—25
§Sunday, Stuart D., 201 E. 33rd Street—18
Supik, William Joseph, 8 E. Eager Street—2
§Supplee, J. Frank, III, 1014 St. Paul Street—2
Sussman, Abram Allen, 3101 N. Charles Street—18
Sussman, Harold, 1701 Eutaw Place—17
Sutherland, George F., 2218 N. Charles Street—18
§Sutley, Percy H., Tally-Ho Road, Lutherville, Md.
Swisher, Kyle Y., Jr., Ligon Road, R.D. #1, Ellicott City, Md.
§Swiss, Adam G., 6232 Belair Road—6
Talbert, John David, 3100 St. Paul Street—18
Tan, George S., 4306 Belle Grove Road—25
Tanenbaum, Solomon, 1250 E. North Avenue—2
§Tankin, Louis H., 3717 Nortonia Road—16
Tansey, John J., The Latrobe—2
Tappan, Benjamin, 6904 Bellona Avenue—12
Taussig, Helen B., Johns Hopkins Hospital—5
Teasdall, Robert D., 8119 Clyde Bank Road—4
Teeter, James H., Franklin Square Hospital—23
Teitelbaum, Harry A., 1801 Eutaw Place—17
Te Linde, Richard W., Johns Hopkins Hospital—5
§Thomas, Anthony J., 4600 York Road—12
Thomas, Caroline Bedell, 700 N. Wolfe Street—5
Thomas, Henry M., 314 Overhill Road—10
Thompson, Raymond Kief, 11 E. Chase Street—2
Thornhill, Joseph E., Baltimore City Hospitals—24
Tilghman, R. Carmichael, 6 E. Eager Street—2
Tillman, Richard Nelson, 3035 St. Paul Street—18
§Tinker, F. X. Paul, 2 Crain Highway, S.W., Glen Burnie, Md.
Tobler, Alice B., Asst. Chief, Bureau of Medical Service &

* Deceased.
§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

Hospitals, 2411 N. Charles Street—18
§Todd, Homer U., 2103 St. Paul Street—18
Toher, James Edmund, 5009 Cedar Avenue—27
Tommasello, Charles J., 1516 Arbutus Avenue—27
§Tompakov, Samuel Victor, 3600 Park Heights Avenue—15
Torrance, Daniel J., Jr., Assistant Professor, Johns Hopkins Hospital—5
Toth, Zsigmund John, 1710 Park Avenue—17
Touhey, T. Joseph, 441 S. Ellwood Avenue—24
§Toulson, W. Houston, Medical Arts Building—1
Tower, Sarah Sheldon, 11 E. Chase Street—2
Towlen, Isidore William, 3710 Hillsdale Road—7
§Townshend, Wilfred H., Jr., 6 St. Georges Road—10
§Traband, Millard T., Jr., 5101 Gwynn Oak Avenue—7
Tramer, Arnold, 6506 Park Heights Avenue—15
§Trescher, John H., 803 Medical Arts Building—1
Trever, Robert William, 1900 McElderry Street—5
Trimble, I. Ridgeway, 2947 St. Paul Street—18
Tseng, Hsiang Len, Provident Hospital, 1514 Division Street—17
Tumminello, S. A., Medical Arts Building—1
§Tunney, Robert B., 7215 York Road—12
Turner, Thomas B., 615 N. Wolfe Street—5
Ugarte, Dario A., 3603 Edmondson Avenue—29
Uhlenhuth, Eberhard H., Johns Hopkins Hospital—5
Ullman, Alfred, 1712 Eutaw Place—1
*Ullrich, Henry Franz, 714 Park Avenue—1
Ullsperger, John F., 5915 Loch Raven Boulevard—12
Urlock, John P., Jr., 1227 Washington Boulevard—30
Valderas, José G., 4802 Lindsay Road—29
Van Berkum, K. A. Peter, 903 Evesham Avenue—12
§Van Buskirk, Charles, Prof. of Neurology, University of Maryland School of Medicine—1
VandeGrift, William B., 211 Ridgemede Road—10
Van Lill, Stephen J., The Carrollton, 3601 Greenway—18
Van Metre, Thomas E., Jr., 1014 St. Paul Street—2
Vasquez, Cesar S., 1213 Light Street—30
§Velez, Baltasar B., 701 Eastern Avenue—21
Venable, Sidney Johnson, Jr., 5808 York Road—12
Vinup, Frederick H., 110 E. Lombard Street—2
Vitale, William J., 5103 Harford Road—14
Vogel, Louis, Jr., 2601 E. Monument Street—5
§Vollmer, Frederick J., 311 Gittings Avenue—12
Von Schulz, Augustine P., 4818 Edmondson Avenue—29
§Voshell, Allen F., Medical Arts Building—1
§Vyner, Harold L., 817 St. Paul Street—2
Wack, Frederic V. D., 513 E. 39th Street—18
Waghelstein, Julius M., 1117 St. Paul Street—2
Wagley, Philip F., 9 E. Chase Street—2
Wainwright, Charles W., 9 E. Chase Street—2
§Walden, Emerson C., Sr., 2329 Harlem Avenue—16
§Walker, A. Earl, 601 N. Broadway—5
§Walker, William W., Medical Arts Building—1
Wall, George H., MC, 218 Fanquier Street, Apt. E-4, Portsmouth, Va.
Wall, Lester Aubrey, Jr., 4407 Underwood Road—18
§Wallenstein, Leonard J., 848 W. 36th Street—11
Waller, W. Kennedy, 3500 N. Calvert Street—18
Walsh, Frank Burton, 14 W. Mt. Vernon Place—1
Walton, Henry J., 3806 Greenway—18
§Ward, Arthur Thomas, 116 Taplow Road—12
*Ward, Grant E., 15 E. Biddle Street—2
Warner, C. Gardner, 7115 Bristol Road—12
Warner, Charles Luther, 3312 Egerton Road—15
Warner, Howard H., 2604 Garrison Boulevard—16
§Warres, Herbert Leonard, 2337 Eutaw Place—17
Wasserman, Harry, 1501 Eutaw Place—1
Waterman, Roger S., 1022 N. Calvert Street—2
Waters, C. A., 1100 N. Charles Street—1
§Webster, Thomas C., 4336 N. Charles Street—18
Weeks, William Earl, 5839 York Road—12
Wehner, Daniel G., Medical Arts Building—1
§Weinberg, E. David, The Latrobe, Charles & Read Streets—2
§Weinberg, J. Arthur, The Latrobe, Charles & Read Streets—2
Weinberg, Paul Charles, 6803 Pimlico Drive—9
Weinberg, Tobias, Hooks Lane—8
Weinberger, Richard, 912 Brooks Lane—17
Weiner, Israel H., 2611 Keyworth Avenue—15
§Weinstock, Alexander A., 4603 Park Heights Avenue—15
Weir, Donald, Dept. of Internal Medicine, Johns Hopkins Hospital—5
Weiss, Albert J., 4115 W. Rogers Avenue—15
Weitzman, Elliott L., 1022 N. Calvert Street—2
Welch, Hugh J., 1205 N. Calvert Street—2
Welch, Robert Bond, Wilmer Institute, Johns Hopkins Hospital—5
§Welcome, Henry C., 1131 Harlem Avenue—17
Welfeld, Alvan A., 1801 Eutaw Place—17
§Wells, George E., 4100 Edmondson Avenue—29
§Wells, George E., Jr., 727 Nottingham Road—29

* Deceased.
§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

§Wells, Gibson J., 3506 N. Calvert Street—18
Wenger, Alvin P., 1100 N. Charles Street—1
Wexler, Jack, 2502 Eutaw Place—17
Wharton, Lawrence R., 1201 N. Calvert Street—2
Wharton, Lawrence R., Jr., Johns Hopkins Hospital—5
Whedbee, James S., Jr., 1118 St. Paul Street—2
White, James E., 5214 Harford Road—14
White, William Kelso, 3005 St. Paul Street—18
Whitham, Lloyd B., 806 Cathedral Street—1
Whitehorn, John C., Johns Hopkins Hospital—5
§Whitehouse, Samuel, 2933 N. Charles Street—18
Whitridge, John, Jr., 2411 N. Charles Street—18
Whittlesey, Philip, 311 Overhill Road—10
Wice, Louis E., 920 St. Paul Street—2
Wich, Joseph Carlton, 614 Coventry Road—4
Wieciech, Michael J., 707 S. Ann Street—31
§Wilder, Earle Maurice, 1719 Eutaw Place—17
Wilder, Milton Jay, 1719 Eutaw Place—17
Wilfson, Daniel, Jr., 5721 Park Heights Avenue—15
§Wilgis, Herbert E., 2947 St. Paul Street—18
Wilkerson, Albert R., 1200 St. Paul Street—2
Wilkins, Lawson, 501 Edgevale Road—10
Wilkinson, William Emmet, Jr., 609 Cathedral Street—1
Will, David Reid, University Hospital—1
Williams, Huntington, 620 W. Belvedere Avenue—10
Williams, M. Lee, 505 Wingate Road—10
Williamson, Charles Vernon, St. Johns Lane, Ellicott City, Md.
Williamson, Edgar P., II, St. Johns Lane, Ellicott City, Md.
§Willson, James K. V., 1100 N. Charles Street—1
Wilson, Harry E., 3 W. Biddle Street—1
Wilson, Harry Thomas, Jr., 1204 St. Paul Street—2
§Wilson, Henry Beatty, 6 E. Eager Street—2
Winkenwerder, Walter L., 1014 St. Paul Street—2
Wise, Walter D., 1120 St. Paul Street—2
Witkin, Erwin, 6807 Maurleen Road—9
Witt, John Philip, The Latrobe, Charles & Read Streets—2
Wohl, Milton J., 3000 Brendan Avenue—13
Wolfe, Samuel B., 1331 E. North Avenue—13
Wolfe, Stewart MacKay, 1551 E. Monument Street—5
§Wolins, Allan Y., 902 Patapsco Avenue—25
§Wollenweber, Henry L., 225 Medical Arts Building—1
Wolman, Samuel, 2424 Eutaw Place—17
Woltereck, Gustav H., 204 Cedarcroft Road—12
Wong, Wyman K., 1313 Dartmouth Avenue—14
Wong, Yung-Tsing, 1 E. Randall Street—30
Wood, Austin H., 323 Medical Arts Building—1
Wood, Orlyn H., 563 Sudbrook Lane—8
Woodland, Charles T., 861 Harlem Avenue—17
Woodruff, James Donald, 600 W. Belvedere Avenue—10
Woods, Alan C., Johns Hopkins Hospital—5
§Woods, Alan C., Jr., 11 E. Chase Street—2
§Woodward, Theodore Englar, 1 Merrymount Road—10
Woody, W. H., 1403 Park Avenue—17
§Workman, Joseph B., University Hospital—1
§Worsley, Thomas L., Jr., 2900 Alameda Boulevard—18
§Wright, Robert B., Medical Arts Building—1
Wurzbacher, Warren W., Hospital for the Women of Maryland—17
Yaffe, Kennard, 5501 Forest Park Avenue—7
§Yaffee, Stanley Norman, 2 E. Read Street—2
§Yeager, George H., Medical Arts Building—1
*York, J. Arthur, Friendship, Md.
§Young, A. Dougal, 1118 St. Paul Street—2
Young, Betty May, 3800 Canterbury Road, Apartment E—18
Young, Elroy, 528 N. Monroe Street—23
§Young, John David, Jr., University Hospital—1
Young, Latimer G., 313 Tunbridge Road—12
Young, N. Louise, 1100 Druid Hill Avenue—17
Young, Ralph J., 1532 E. Monument Street—5
Yousem, Herbert L., 05202395, 60th Station Hospital, APO 256, New York, N. Y.
Zadek, Robert, Baltimore City Hospitals—24
Zassenhaus, H. Margret, 6106 Chinquapin Parkway—12
Zeligman, Israel, 1109 N. Calvert Street—2
Zeller, Eugene, 2739 Eastern Avenue—24
§Zerzavy, Frederick M., 17 Regester Avenue—12
Ziegler, Frederick Joseph, Johns Hopkins Hospital—5
Ziegler, Paul R., 3723 Edmondson Avenue—29
§Zierler, Joseph N., 2318 Eutaw Place—17
Zimmerman, Loy M., 3202 Harford Road—18
Zinberg, Israel S., 2320 Eutaw Place—17
Zheutlin, Harold E. C., 1112 N. Calvert Street—2
Zinn, Waitman F., Medical Arts Building—1

Associate Members

Ablaza, Sariel G. G., Hahnemann Hospital, N. Broad Street, Philadelphia, Pa.
Adams, John Edward, 810 E. Belvedere Avenue—12

* Deceased.
§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

Adhikari, Kiran Chandra, Baltimore City Hospitals—24
Akel, Roger, Baltimore City Hospitals—24
Amberson, William R., Cockeysville
Apostolidis, Panayotis, Union Memorial Hospital—18
Arizaga, J. Rolando, Spring Grove Hospital—28
Aronovitz, Gerson, Baltimore City Hospitals—24
Attar, Safuh M. A., Mercy Hospital—2
Avila, Justo S., Jr., Union Memorial Hospital—18
Baca, Manual, Baltimore City Hospitals—24
Bagusin, Alexis Matthew, 5726 Cross Country Boulevard—9
Barrabini, Andre, 310 Folcroft Street—24
Barranco, Frank Thomas, 1212 Argonne Drive—18
Bedwell, Stephen F., Baltimore City Hospitals—24
Bennett, William P., 4453 d USAF Hospital, SHAW AFB, South Carolina
Bensimon, Joseph, Baltimore City Hospitals—24
Bernstein, Milton, 3202 Taney Road—15
Berstock, Edwin Jack, Hospital for Women of Maryland—17
Bishai, Yousef B., Baltimore City Hospitals—24
Bluestein, David D., Baltimore City Hospitals—24
Boennec, Yves H., Hospital for the Women of Maryland—17
Bongiovanni, John R., Baltimore City Hospitals—24
§Brewer, John H., 425 Oak Lane—4
Broderick, Francis Lawrence, Union Memorial Hospital—18
Bruno, Carmelo, Baltimore City Hospitals—24
Buettner, Henry F., 5005 Edmondson Avenue—29
Burt, Fred, Baltimore City Hospitals—24
Busch, Edwin S., 1516 E. 33rd Street—18
Campbell, Colin, Hospital for the Women of Maryland—17
Cerino, Michele, Union Memorial Hospital—18
Chang, Young Chan, 1501 Park Avenue—17
Charache, Patricia, Baltimore City Hospitals—24
Chen, Thomas Tao-Yuan, 200 E. 34th Street—18
Cheung, Che-Sun, Baltimore City Hospitals—24
Choi, Ock Soon, 1501 Park Avenue—17
Clark, Fred H., 3610 Gwynn Oak Avenue—7
Cole, Fred N., Jr., Union Memorial Hospital—18
Cunanan, Jose F., Baltimore City Hospitals—24
Davies, Edward Ross, 508 Rossiter Avenue—12
Davis, Joseph W., 326 Radnor Avenue—12
deFesus, Andre, 14 W. Mt. Vernon Place—1
deFries, Hugh O., Union Memorial Hospital—18
de Leon, Augusto R., Church Home & Hospital—31
De Leon, Natividad, Hospital for Women of Maryland—17
Del Rosario, David R., Baltimore City Hospitals—24
Dumlu, Ahmet Tarik, Baltimore City Hospitals—24
Duvall, Robert Caywood, 1838 Locust Ridge Road, Timonium
Eguia, Oscar, 333 Drew Street—24
Escarraga, Lourdes Aguto, 422 Bonsal Street—24
Fahey, John J., Baltimore City Hospitals—24
Fernandez, Augusto, St. Joseph's Hospital—13
Fernandez, Efraim, St. Joseph's Hospital—13
Fernandez, Ligia M., Baltimore City Hospitals—24
Fernandez, Luis, St. Joseph's Hospital—13
Fink, Arthur I., 724 W. North Avenue—17
Fishburn, Howard D., U.S. Public Health Hospital—11
Fletcher, Herbert E., 2936 Harford Road—18
Fox, Thomas Edward, Lahey Clinic, 605 Commonwealth Avenue, Boston, Mass.
Frankel, N. Ralph, Baltimore City Hospitals—24
Frankel, Samuel S., 2022 W. Rogers Avenue—9
Freeman, Irving, 5734 Greenspring Avenue—9
Gakenheimer, W. Alfred, 108 W. 39th Street—10
Garcia, Rafael, Baltimore City Hospitals—24
Gatewood, William M., 106 New Hope Street, Plymouth Valley, Norristown, Pa.
Geldrich, John, 1400 N. Caroline Street—13
Gey, George O., 6017 Lakehurst Drive—10
Gil, Carlos Medina, Union Memorial Hospital—18
Gilles, Floyd H., Baltimore City Hospitals—24
§Ginsberg, Milton, 3504 Erdman Avenue—13
Gladue, J. Raymond, 1538 Shadyside Road—18
Goco, Rolando V., Church Home & Hospital—31
Goldsmith, Harry, 3109 Marmot Road—8
Grainger, Sybil D., 3707 W. Franklin Street—29
Grant, Philip Shepard, Hospital for Women of Maryland—17
§Green, Charles R., Jr., Asst. Chief, Obstetrics & Gynecology, Baltimore City Hospitals—24
Griffey, Walter P., U.S. Public Health Service Hospital—11
Guy, Charles, Baltimore City Hospitals—24
Haji-Morad, Ali, Baltimore City Hospitals—24
Harper, Ian Stewart H., Apt. C, 4534 N. Charles Street—10
Harper, William Sinclair, Route #1, Box 731, Martin Drive—21
Hartley, Bryan, Union Memorial Hospital—18
Helgasom, August H., Baltimore City Hospitals—24
Helwig, Floy C., Baltimore City Hospitals—24
Hernandez, Esteban, Baltimore City Hospitals—24
Hogg, Frederick R., Baltimore City Hospitals—24
Hohing, Charles Conrad, Hospital for the Women of Maryland—17
Idea, Braulio V., Church Home & Hospital—31

§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

Jensen, Jacob Roed, Veterans Administration Hospital—18
Jones, Beverley B., 537 N. Wolfe Street—5
Joven, Lucrecia F., Union Memorial Hospital—18
Kac, Arthur, 3606 Oak Avenue—7
Kahaleh, Rateb, University Hospital—1
Kalish, John T., 1731 Waverly Way—12
Kanner, Leo, 4510 Wentworth Road—7
Katz, Albert H., 3855 Forest Park Avenue—16
Kendros, Socrates I., 69 Merrill Road—28
Kessler, Susan, Baltimore City Hospitals—24
Keuls, Hans-Adriaan, Union Memorial Hospital—18
Khurana, Kishan Das, Baltimore City Hospitals—24
Kime, Watson P., 3707 W. Franklin Street—29
Kingstone, Eddie, Baltimore City Hospitals—24
Kitiowski, Edward J., 805 St. George Road—10
Kizilay, Dogan, Baltimore City Hospitals—24
Koller, E. Curtis, 8320 Beryl Road—14
Kolliker, Klaus A., Union Memorial Hospital—18
Kopits, Imre, Gawanda State Hospital, Helmuth, N. Y.
Kramer, Howard C., Apt. H6, Beach Drive—20
Kramer, William M., 1767 Northern Parkway—12
§Krantz, John C., Jr., 7824 Ellenham Road—4
Kukita, Kazuko, Baltimore City Hospitals—24
Lai, Daniel G., Montebello Hospital—18
Lainez-Lozada, Cesar, St. Joseph's Hospital—13
Landavere, Nicholas, St. Joseph's Hospital—13
Larkey, Sanford Vincent, Welch Medical Library, Johns Hopkins Hospital—5
Latham, Ernest F., U.S.N., Station Hospital, Naval Air Station, Quonset Point, Rhode Island
Layug, Pelagio E., St. Joseph's Hospital—13
Lazaro, Benigno R., 1514 Division Street—17
Lazaro, Melquides, Union Memorial Hospital—18
Lee, K. Y., St. Joseph's Hospital—13
Levin, Solomon, Baltimore City Hospitals—24
Lew, Hea Rean, Hospital for Women of Maryland—17
Lew, Young Hea, Hospital for Women of Maryland—17
Lim, Fermina T., Union Memorial Hospital—18
Linville, James T., 2215 Sieger Villa, Louisville 18, Ky.
Lippman, Eli M., 405 Milford Mill Road—8
Loughead, John R., Jr., 5751 Academy Street, Tucson 15, Arizona
McElfatrick, George C., Veterans Administration Hospital, Ft. Howard, Md.
McGovern, John M., 1516 Bolton Street—17
McKee, L. Clifford, Jr., Baltimore City Hospitals—24
Macgowan, Birkhead, 11 E. Read Street—2
MacGregor, Alexander H., Baltimore City Hospitals—24
Mackenzie, Thayer M., U.S. Public Health Service Hospital—11
Maginnis, Helen Irene, New Cut Road, Ellicott City, Md.
Martin, Robert E., 215 E. 32nd Street—18
Matusky, William E., Baltimore City Hospitals—24
Mehta, Raghu N., Baltimore City Hospitals—24
Miguel, Milagros A., Unity Hospital, 1544 St. John's Place, Brooklyn 13, N. Y.
Mitani, Thomas T., St. Joseph's Hospital—13
Mitchell, Robert Bruce, 4 E. 32nd Street—18
Morgan, Norman Daniel, Jr., Baltimore City Hospitals—24
Motley, Virgil Atwell, Route 4, Box 22-B, Morgantown, W. Va.
Naval, Guillerma S., Baltimore City Hospitals—24
Nelson, Alfred S., U.S.P.H.S. Hospital, Wyman Park Drive—11
Nussbaum, Kurt, 207 Clarendon Avenue—8
Oleynick, A. Harry, Baltimore City Hospitals—24
Oremland, Fred, Baltimore City Hospitals—24
Ozbek, Resit Erdogan, Hospital for the Women of Maryland—17
Pak, Ok Kyung, Union Memorial Hospital—18
Pak, Yong Kun, % Mrs. Dore, 829 Park Avenue—1
Palafox, Asuncion L., Lincoln Hospital, E. 141st & Concord Avenue, New York 54, N.Y.
Palladino, Antonio, Baltimore City Hospitals—24
Park, Chang Joon, Baltimore City Hospitals—24
Pascual, Anita S., Baltimore City Hospitals—24
Paulino, Adoracion De Borja, 1426 John Street—17
Paulino, Pedro P., Church Home & Hospital—31
Peralta, Conrado N., South Baltimore General Hospital—30
Peterson, Natalie, 1413 Park Avenue—17
Phillips, Raymond Earle, 5802 Willowton Avenue—14
Pollock, Alexander, Baltimore City Hospitals—24
Poole, Norman L., Baltimore City Hospitals—24
Porturas, Alvaro, St. Joseph's Hospital—13
Puig, Luisa O., Baltimore City Hospitals—24
Quinones, Jose, Baltimore City Hospitals—24
Raiber, Richard, Hospital for the Women of Maryland—17
Ramirez, Dominga C., 1413 Park Avenue—17
Redd, Henry J., Jr., Baltimore City Hospitals—24
Reid, Robert, Baltimore City Hospitals—24
Reilly, William Anthony, Baltimore City Hospitals—24
Renick, Anderson M., Jr., R.D. #4, Deyerle Road, Roanoke, Va.
Richter, Curt Paul, Phipps Psychiatric Clinic, Johns Hopkins Hospital—5
Rink, Heldi, Baltimore City Hospitals—24

§ Wife ia a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

Robinson, Daniel R., V. A. Hospital, Ft. Howard 19, Md.
Rodriguez, Victor, St. Joseph's Hospital—13
Roilidis, George V., 1400 N. Caroline Street—13
Ross, Harry Paul, Sacred Heart Hospital, Norristown, Pa.
Rubin, Jesse, Baltimore City Hospitals—24
Russell, Edgar Alexander, Baltimore City Hospitals—24
§Russo, Sebastiano, 5017 Harford Road—14
Saar, Artur, 1709 Linden Avenue—17
Sadarananda, Vatana, Church Home & Hospital—31
Samson, Celia G., 1413 Park Avenue—17
Sanders, John A., Baltimore City Hospitals—24
Sarkissian, Anna, Church Home & Hospital—31
Sathe, Shanta Sadashiv, Baltimore City Hospitals—24
Schneidmuhl, Abraham M., 3340 Dolfield Avenue—15
Schoen, Sheldon S., Baltimore City Hospitals—24
Shelling, Richard, Baltimore City Hospitals—24
Silverman, Charlotte, Md. State Department of Health, 2411 N. Charles Street—18
Sinton, William A., Jr., 52 Martha Avenue, Wrightstown, N.J.
Skaggs, James W., Jr., 1024 Wisconsin Avenue, N.W. Washington 7, D.C.
Slockbower, Edith T., Oakdale, Iowa
Smith, Edward P., Jr., 223 Fairchild, Lackland Village, San Antonio, Texas
Smith, James Alexander, U.S. Public Health Service Hospital—11
Stazio, Antonio, Baltimore City Hospitals—24
Steichen, Felicien M., Baltimore City Hospitals—24
Steingaszner, Laszlo, 1401 Park Avenue—17
§Storey, Patrick B., 3900 Loch Raven Boulevard—18
Striar, Ronald R., Baltimore City Hospitals—24
Strohhofer, Anton, Pine Camp Hospital, Richmond, Va.
Stuck, Robert George, 10 Northway Avenue, Wollcott, N.Y.
Taavon, Homayoon, Baltimore City Hospitals—24
Tangatue, Maria L. G., Baltimore City Hospitals—24
Tasker, Arthur N., 317 Tuscany Road—10
Thamer, Mahmud, Baltimore City Hospitals—24
Trascosopoulou, Athina N., Baltimore City Hospitals—24
Traugott, Karl, 1912 E. Belvedere Avenue—14
Trimble, Frances Hartley, 6006 Charlesmeade Road—12
Turgut, Oguz, St. Joseph's Hospital—13
Vajaranant, Manit, Hospital for the Women of Maryland—17
Veneracion, Roland B., Church Home & Hospital—31
§Villa Santa, Umberto, 4611 Cedar Garden Road—29
Weil, Peter, Baltimore City Hospitals—24
Whang, Robert, Baltimore City Hospitals—24
Wilder, Robert J., Baltimore City Hospitals—24
Willner, Richard Lewis, Baltimore City Hospitals—24
Wilson, Harry Davis, Jr., New York Hospital, 525 E. 68th Street, New York 21, N.Y.
Wiswell, John G., Baltimore City Hospitals—24
Wylie, H. Boyd, 715 Scarlett Drive—4
Yuan, Y. K., 3810 S. Hanover Street—25
Yund, Ihsan, Baltimore City Hospitals—24
Zapata, Alberto, St. Joseph's Hospital—13
Zepeda, Agustin R. Y., 6214 Plantview Way—24
Zirkle, Walter M., 2804 Virginia Road, Augusta, Ga.
Zucker, Howard Smylie, Baltimore City Hospitals—24

Baltimore County

§Allison, Robert Herschel, 4 York Road, Towson 4, Md.
§Anderson, William A., Lutherville, Md.
§Andrew, David Holmes, 33 Dundalk Avenue, Baltimore 22, Md.
Angell, Edward D. M., A03075928, 4737 A.F. Hospital, ADC. APO 826, New York, N.Y.
Armacost, Joshua H., Mt. Wilson Hospital, Mt. Wilson, Md.
§Baier, John C., 540 Stemmers Run Road, Baltimore 21, Md.
§Barry, Michael C., 55 Manor Drive, Newark 6, New Jersey
Barstow, Mary V. M., Bradshaw, Md.
Baumann, Eugene C., 413 Eastern Avenue, Baltimore 21, Md.
§Baumgardner, George M., 8552 Philadelphia Road, Baltimore 6, Md.
§Beck, Irving R., 901 Fuselage Avenue, Baltimore 20, Md.
§Beitler, Frederic V., 1014 Francis Avenue, Baltimore 27, Md.
Benson, Edward H., 1125 Ramblewood Road, Baltimore 12, Md.
§Berrios-Jimenez, Osvoldo, 7526 Holabird Avenue, Baltimore 22, Md.
§Bisanar, James Milton, 501 Sussex Road, Towson 4, Md.
§Block, Nathan, 6200 Verdene Avenue, Baltimore 9, Md.
§Bociek, Stanley, 906 "C" Street, Sparrows Point, Baltimore 19, Md.
§Bridges, William A., 10 Othoridge Road, Lutherville, Md.
§Bubert, John D., Wyman Park Apartments, Apt. 506, Baltimore 11, Md.
§Burns, Harold Hubert, 115 E. Eager Street, Baltimore 2, Md.
§Burns, John Howard, Jr., 59 Dundalk Avenue, Dundalk 22, Md.
§Cameron, Joseph J., 711 Hickory Lot Road, Baltimore 4, Md.
§Caples, D. Delmas, 6 Hanover Road, Reisterstown, Md.
Carroll, Douglas Gordon, Brooklandville, Md.
§Chance, Lester T., 11 E. Chase Street, Baltimore 2, Md.
Chatard, Ferdinand E., IV, 222-A Route 7, Pikesville 8, Md.
§Cianos, James Nicholas, The Latrobe Apartments, Baltimore 2, Md.
Clarke, S. R., E. Morris Avenue, Lutherville, Md.

§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

§Collins, Jack C., 7622 Dunmanway, Baltimore 22, Md.
Cowen, Joseph Robert, Sheppard & Enoch Pratt Hospital, Baltimore 4, Md.
Cushing, Jean George N., 2 E. Read Street, Baltimore 2, Md.
Cushing, Mary McK., 2 E. Read Street, Baltimore 2, Md.
§Dalmau, Louis Z., Pikesville Medical Center, Pikesville 8, Md.
Daugharthy, A. Bradley, 1264 Francis Avenue, Halethorpe 27, Md.
Daugharthy, Roselva T., 1264 Francis Avenue, Halethorpe 27, Md.
§Dausch, Michael J., 4636 Belair Road, Baltimore 6, Md.
Davens, Edward, 6141 Barroll Road, Baltimore 9, Md.
§Davis, George H., 404 Hollen Road, Baltimore 12, Md.
§Davis, Melvin B., 2910 Dunleer Road, Dundalk 22, Md.
§D'Elia, Laurence N., Jr., 121 Forest Avenue, Baltimore 28, Md.
§DeLeon, Manuel P., 2816 Plainfield Road, Baltimore 22, Md.
§Depner, Rudolph, 114 Forest Drive, Baltimore 28, Md.
De Vasconcellos, John B., 44 Maple Drive, Baltimore 28, Md.
§Doss, Richard H., 6229 N. Charles Street, Baltimore 12, Md.
Dudley, Winston C., 3506 Millvale Road, Baltimore 7, Md.
§Dunton, William R., Apt. B-1, 3024 N. Calvert Street, Baltimore 18, Md.
§Edwards, David E., Spring Grove State Hospital, Baltimore 28, Md.
§Edwards, George D., 8019 Philadelphia Road, Baltimore 6, Md.
Edwards, W. Hunter, Sheppard & Enoch Pratt Hospital, Baltimore 4, Md.
§Ellicott, V. L., 22 Buchanan Road, Baltimore 12, Md.
§Ensor, Charles B., 7201 York Road, Baltimore 12, Md.
§Ensor, Robert Ellwood, 621 Hastings Road, Baltimore 4, Md.
§Evans, Eugene R., 1 Liberty Parkway, Dundalk 22, Md.
§Farber, Dawson L., 914 D Street, Baltimore 19, Md.
§Fargo, Lee K., 8155 Loch Raven Boulevard, Baltimore 4, Md.
Fleischman, Gertrude J., Spring Grove Hospital, Catonsville 28, Md.
§Flick, Elliott C., 108 Edgewood Road, Towson 4, Md.
§France, A. M., Parkton, Md.
§Gallager, Wilmer K., 6209 Frederick Road, Catonsville 28, Md.
§Gessner, John E., 851 Middlesex Road, Baltimore 21, Md.
§Gilmore, George T., Lanham Building, Lutherville, Md.
§Goldstein, Eugene O., 1310 Churchill Drive, Pikesville 8, Md.
§Golombek, Leonard H., 7013 Liberty Road, Baltimore 7, Md.
Gonzalez, Caridad E., 7405 Belair Road, Baltimore 6, Md.
§Goodman, William, 1334 Sulphur Spring Road, Arbutus 27, Md.
§Grau, Edward Gordon, 8523 Loch Raven Boulevard, Towson 4, Md.
§Green, Waverly S., Jr., Berryman Lane, Reisterstown, Md.
§Halperin, Herman J., Bethlehem Steel Company, Baltimore 19, Md.
§Hammett, Walter M., Baldwin, Md.
§Hening, R. M., 203 Ingleside Avenue, Baltimore 28, Md.
§Hetherington, Leon H., 6511 Darnall Road, Ruxton 4, Md.
Hiller, Grace, 500 Bosley Avenue, Towson 4, Md.
§Hodil, Elmer R., Mt. Wilson, Md.
§Holden, F. A., Medical Arts Building, Baltimore 1, Md.
§Hollander, Mark, Medical Arts Building, Baltimore 1, Md.
§Howell, Clewell, 102 Alleghany Avenue, Towson 4, Md.
§Howell, James G., 715 Frederick Road, Catonsville 28, Md.
§Hudson, Clifford F., Fork, Md.
Hudson, Rollin C., 606 Baltimore Avenue, Baltimore 4, Md.
§Hyle, John Charles, 7527 Belair Road, Baltimore 6, Md.
§Jacobson, Wayne E., Sheppard & Enoch Pratt Hospital, Towson 4, Md.
Johns, Viola B., Rosewood Training School, Owings Mills, Md.
§Junk, Ivan De Kalb, Randallstown, Md.
§Kasik, Frank T., 9005 Harford Road, Baltimore 14, Md.
§Kees, Walter T., Cockeysville, Md.
Kenworthy, Richard A., III, 75 Linden Street, Brattlesboro, Vermont
§Kieffer, George S. M., 1010 Leeds Avenue, Baltimore 29, Md.
Kolodny, A. L., 2503 Shellydale Drive, Baltimore 9, Md.
§Kramer, Irving, 700 Reisterstown Road, Baltimore 8, Md.
§Landau, S. Walter, 23 Hanover Road, Reisterstown, Md.
Languth, Helen W., 11 E. Chase Street, Baltimore 2, Md.
§Lichtenberg, Joseph D., 11 E. Chase Street, Baltimore 2, Md.
*Johnson, S. Lloyd, 6348 Frederick Road, Catonsville 28, Md.
McClinton, Isabel H., Kingsville, Md.
McGrath, William Edward, 1303 Frederick Road, Catonsville 28, Md.
§McWilliams, Clarence E., Reisterstown, Md.
§Magness, Stephen L., 21 Overhill Road, Baltimore 28, Md.
§Martin, William E., Randallstown, Baltimore, Md.
Matthews, Mary, Baltimore County Health Department, Towson 4, Md.
§Means, James T., 503 Surrey Road, Timonium, Md.
§Medairy, George C., Rosewood Sanatorium, Owings Mills, Md.
§Merrill, George G., 100 E. Chase Street, Baltimore 2, Md.
§Miceli, Joseph, 108 S. Taylor Avenue, Baltimore 21, Md.
§Miller, James A., Reisterstown Road & Walker Avenue, Baltimore 8, Md.
Morrison, W. Herbert, 3 Kingships Road, Baltimore 22, Md.
§Mund, Maxwell H., 417½ Eastern Avenue, Essex 21, Md.
§Murdock, Harry Merrill, Sheppard Pratt Hospital, P.O. 6814, Towson 4, Md.
§Nachlas, N. Edward, 2108 Eutaw Place, Baltimore 17, Md.
§Nevy, Eugene F., 7001 Mornington Road, Dundalk 22, Md.
§Newcomer, William, Mount Wilson, Md.
§Nichols, Joseph Harold, 9 South Lane, Baltimore 22, Md.

* Deceased.
§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

Nolan, James J., 416 Kensington Road, Baltimore 29, Md.
§Novey, Samuel, 11 E. Chase Street, Baltimore 2, Md.
§O'Donnell, Charles Francis, 7501 York Road, Baltimore 4, Md.
§Owens, David, 914 D. Street, Baltimore 19, Md.
Pao, Ping-Nie, The Livingston Apartment, 5437 Connecticut Avenue, N.W., Washington, D.C.
§Parr William A., The Latrobe, Charles & Read Streets, Baltimore 2, Md.
*Parson, Willard S., 1711 Selma Avenue, Baltimore 27, Md.
§Perkins, Clifton T., 646 Charles Street, Towson 4, Md.
§Pierpont, Edwin L., 8204 Liberty Road, Baltimore 7, Md.
§Pillsbury, William A., Jr., Timonium, Md.
Post, Lawrence Caldwell, 6805 York Road, Baltimore 12, Md.
§Pound, J. Costello, 104 N. Rolling Road, Baltimore 28, Md.
Powder, James R., Lanham Building, Lutherville, Md.
Pratt, Louis J., Jr., 8402 Greenway Road, Towson 4, Md.
§Quinn, Kevin, Timonium, Md.
§Radauskas, Bruno, Spring Grove State Hospital, Baltimore 28, Md.
§Rainess, Morris, 2900 Dunran Road, Baltimore 22, Md.
§Randol, Charles Lee, 808 Reisterstown Road, Pikesville 8, Md.
Rappoport, Jonas Ralph, 3610 Woodbine Avenue, Baltimore 7, Md.
§Reese, J. Morris, Medical Arts Building, Baltimore 1, Md.
§Rehberger, John M., Phoenix, Md.
§Reier, Charles H., Dunkirk & York Road, Baltimore 12, Md.
Richards, C. Victor, 321 Dunkirk Road, Baltimore 12, Md.
§Rigler, Richard R., 1 West Overlea Avenue, Baltimore 6, Md.
Riley, Robert H., 100 N. Beechwood Avenue, Catonsville 28, Md.
§Robinson, Miles H., 1306 Dulaney Valley Road, Baltimore 4, Md.
§Rodgers, William A., 815 Eastern Avenue, Baltimore 21, Md.
Roemmich, William, Box 602, Field Road, Pikesville 8, Md.
§Roop, Donald, 1112 Hampton Garth, Baltimore 4, Md.
§Rothstein, Leonard M., 2500 Eutaw Place, Baltimore 17, Md.
§Royse, Paul H., 718 Cliveden Road, Pikesville 8, Md.
§Runkel, John G., 715 Charing Cross Road, Baltimore 29, Md.
§Saffell, James Glen, 64 Main Street, Reisterstown, Maryland
§Sanner, J. Everett, 159 W. Lanvale Street, Baltimore 17, Md.
§Sargent, G. F., Aigburth Road, Towson 4, Md.
§Sauer, Elmer P., Mt. Wilson, Md.
§Scalia, Samuel P., 1331 Reisterstown Road, Baltimore 8, Md.
§Schlenoff, Milton, 6410 Windsor Mill Road, Baltimore 7, Md.
§Seabold, William Merven, 5402 Edmondson Avenue, Baltimore 29, Md.
§Sedlack Joseph Arthur, 200 W. Pennsylvania Avenue, Towson 4, Md.
§Semenoff, Louis, 1117 Orems Road, Baltimore 20, Md.
§Shear, Joseph, 805 Fuselage Avenue, Baltimore 20, Md.
Sherrard, Margaret Lee, 1200 E. 36th Street, Baltimore 18, Md.
Sherrill, Elizabeth B., Cockeysville, Md.
§Siedenburg, Richard H., 1309 St. Albans Road, Baltimore 8, Md.
§Siwinski, Thaddeus Charles, 17 W. Pennsylvania Avenue, Baltimore 4, Md.
§Smith, William Meredith, 201 Edgevale Road, Baltimore 10, Md.
§Sollod, Bernard W., 2231 Crest Road, Baltimore 9, Md.
§Somerville, Donald L., 25 W. Pennsylvania Avenue, Baltimore 4, Md.
§Spelsberg, Walter Karl, 903 Pemberton Road, Baltimore 12, Md.
§Spragins, Melchijah, 102 Allegheny Avenue, Towson 4, Md.
§Strobel, Martin E., 59 Hanover Road, Reisterstown, Md.
§Thomas, Joseph Henry, 8134-A Bullneck Road, Dundalk 22, Md.
§Thomas, Ramsay B., 4123 Frederick Avenue, Baltimore 29, Md.
Thomas, Robert E., 8521 Oakleigh Road, Baltimore 14, Md.
§Tollin, Louis M., 6908 North Point Road, Baltimore 19, Md.
Traynor, Francis W., Everett Road, Monkton, Md.
§Tuerk, Isadore, Spring Grove State Hospital, Catonsville 28, Md.
§Urban, George E., 803 Frederick Road, Catonsville 28, Md.
§Wade, William C., 140 Oak Avenue, Dundalk 22, Md.
§Warthen, William H. F., 611 Hillen Road, Towson 4, Md.
§Weinberg, Harold H., 8821 Liberty Road, Randallstown, Md.
Wheeler, H. Lawrence, 9 Paradise Avenue, Catonsville 28, Md.
§Wheeler, Thomas E., 3601 Clifmar Road, Baltimore 7, Md.
§Whitehead, Hugh G., Jr., 1201 N. Calvert Street, Baltimore 2, Md.
Wilkinson, A. L., St. Michaels, Md.
§Williams, Charles Herman, 1632 Reisterstown Road, Pikesville 8, Md.
§Williams, Palmer F. C., 1725 Reisterstown Road, Pikesville 8, Md.
§Williams, Robert R., 6603 Eastern Parkway, Baltimore 14, Md.
§Windsor, Roger Gilbert, 520 D Street, Sparrows Point 19, Md.
§Zalis, Daniel, 1942 Cedar Lane, Baltimore 22, Md.

Calvert County

DeVillarreal, Roberto, Prince Frederick, Md.
§Jett, Page C., Prince Frederick, Md.
§Ward, Hugh W., Owings, Md.

Caroline County

Anderson, F. M., Federalsburg, Md.
§George, D. O., Denton, Md.
Kingsbury, Robert, Federalsburg, Md.
§Knotts, E. Paul, 406 Market Street, Denton, Md.
Lennon, W. E., Federalsburg, Md.
Plummer, Harold B., Preston, Md.
Riley, Edwin G., Denton, Md.
*Silver, H. Fletcher, Goldsboro, Md.
Stonesifer, Charles H., Greensboro, Md.
Winnacott, Charles H., Ridgely, Md.
Wright, Robert, Greensboro, Md.

* Deceased.
§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

Carroll County

Bare, S. Luther, Westminster, Md.
Billingslea, Charles L., Westminster, Md.
Bush, Joseph E., Hampstead, Md.
§Chepko, Julius, Westminster, Md.
Culwell, William B., Mt. Airy, Md.
§Foard, Wilbur H., Manchester, Md.
Foutz, Charles R., Westminster, Md.
Gardner, Robert E., Springfield State Hospital, Sykesville, Md.
Gau, Bertrand C. R., Central Avenue, Sykesville, Md.
Gross, Gertrude, Sykesville, Md.
Gross, Martin, Springfield State Hospital, Sykesville, Md.
Hall, Howard E., Sykesville, Md.
Hitchman, Irene, Springfield State Hospital, Sykesville, Md.
§Jennette, W. C., Westminster, Md.
John, Joseph R., Jr., A.P.O. 827, New Orleans, La.
Kamm, Ilse, Sykesville, Md.
§Lawson, William H., Eldersburg, Md.
§McVaugh, R. S., Taneytown, Md.
Margolin, Ellis S., Sykesville, Md.
§Marsh, James T., 109 E. Main Street, Westminster, Md.
§Mastin, Morrell M., Sykesville, Md.
Mead, Henry C. A., Winder Point, Easton, Md.
§Moulton, George Allen, Jr., Westminster, Md.
Porterfield, M. C., Hampstead, Md.
§Robertson, Merritt, New Windsor, Md.
Schochet, George, Health Department, Westminster, Md.
*Sonnenfeldt, Gertrud, Springfield State Hospital, Sykesville, Md.
*Sonnenfeldt, Walter H., Springfield State Hospital, Sykesville, Md.
Speicher, Wilbur G., Westminster, Md.
Stewart, William L., Post Office, Edgewood, Md.
Takahashi, Yosuo, Springfield State Hospital, Sykesville, Md.
Thompson, E. Ambler, Taneytown, Md.
Vestal, Thomas, Victor Cullen Hospital, Cullen, Md.
Welliver, Daniel I., 19 N. Church Street, Westminster, Md.
Wilkins, Elizabeth Reese, Westminster, Md.
§Woodward, Lewis K., Westminster, Md.

Cecil County

§Andrews, S. Ralph, 233 E. Main Street, Elkton, Md.
Bates, J. Herbert, 230 E. Main Street, Elkton, Md.
Benson, C. I., Port Deposit, Md.
*Brannon, E. P., Veterans Administration Hospital, Coatesville, Pa.
Brooks, Clifton R., 269 E. Main Street, Newark, Del.
Byers, John M., Health Department, Elkton, Md.
§Cantwell, H. A., Cecil Avenue, North East, Md.
Cuza, Luis M., North East, Md.
§Davis, H. Vincent, Chesapeake City, Md.
§Dodson, Richard C., Rising Sun, Md.
Ells, Elizabeth S., Veterans Administration Hospital, Perry Point, Md.
Eppes, Williford, 325 E. Main Street, Newark, Del.
Fischer, John A., Christiana Turnpike, R.D. 4, Elkton, Md.
§Garey, James Lyman, 42 Graceford Drive, Aberdeen, Md.,
Goldgraben, Seymour, Veterans Administration Hospital, Perry Point, Md.
Goldmeier, Erich, Veterans Administration Hospital, Perry Point, Md.
§Huebner, Klaus H., Cecil Avenue, North East, Md.
Johnson, James L., 245 E. High Street, Elkton, Md.
Kreis, George J., Jr., 201 E. Main Street, Elkton, Md.
McKnight, Vernon H., 113 Bridge Street, Elkton, Md.
Magraw, James F., Perryville, Md.
Morrison, Winfred T., Earleville, R. D. 1, Md.
Munday, Perry L., 249 E. Main Street, Newark, Del.
§Obenshain, Wallace, Cecilton, Md.
Richards, G. Hampton, Port Deposit, Md.
Rothfeld, Ben, Perry Point, Md.
§Sadowsky, Wallace H., Perryville, Md.
Spangler, Henry A., Elkton R.D., Md.
Sprecher, Milford H., 135 W. Main Street, Elkton, Md.
Stavrakis, Peter, 154 W. Main Street, Elkton, Md.
Taylor, Neil, Rising Sun, Md.
Twining, Ralph H., Veterans Hospital, Perry Point, Md.

Charles County

Andrews, James E., 17 Potomac Avenue, Indian Head, Md.
Bicknell, George C., Indian Head, Md.
Coburn, Harry R., Bryantown, Md.
Dettor, Vernon B., La Plata, Md.
§Edelen, Edward J., La Plata, Md.
Griffin, John H., Hughesville, Md.
*Higdon, Thomas L., Wayside, Md.
Jarboe, J. Parran, La Plata, Md.
Johnson, Frederick M., La Plata, Md.
Susan, Frank A., Indian Head, Md.
Weber, George S., Waldorf, Md.
Wooddy, Arthur, La Plata, Md.

Dorchester County

§Baumann, Wilbur N., Cambridge, Md.
Bunker, Albert E., 200 Maryland Avenue, Cambridge, Md.
Burdette, Lewis M., Cambridge, Md.
Currier, George, Eastern Shore State Hospital, Cambridge, Md.
De Filippis, Eltore, Eastern Shore State Hospital, Cambridge, Md.
Dredge, Thomas, Cambridge, Md.
Gunby, Walter E., Jr., Cambridge, Md.
§Hanks, William H., Cambridge, Md.
Harrison, William C., Hurlock, Md.
Jones, Kenneth B., Church Creek, Md.
Lambkin, Edward E., Charles & 31st Streets, Homewood Apartments, Apt. 3-D, Baltimore 18, Md.
§Mace, John, Jr., 6 Church Street, Cambridge, Md.
§Maryanov, Alfred R., Cambridge, Maryland.
Maryanov, Lawrence, 136 Race Street, Cambridge, Md.
Meekins, Gilbert E., Cambridge, Md.
Miller, Frederick A., Cambridge, Md.

* Deceased.
§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

Miller, Robert B., 805 E. Seminary Avenue, Towson 4, Md.
Thompson, James Upshur, Cambridge, Md.
Tinsman, Clarence A., 4231 Orchard Hill Road, Harrisburg, Pa.
Traub, Eugene, R. F. D. #3, Cambridge, Md.
Virkutis, Simon, Eastern Shore State Hospital, Cambridge, Md.
Ward, Edwin Janvier, Eastern Shore State Hospital, Cambridge, Md.
West, G. Brooks, Jr., Cambridge, Md.
Winiarz, Elizabeth A., 327 West End Avenue, Cambridge, Md.
Winiarz, Witold V., 327 West End Avenue, Cambridge, Md.
§Wolff, Eldridge H., 15 Locust Street, Cambridge, Md.

Frederick County

Ash, Howard W., 221 E. Church Street, Frederick, Md.
Baer, Ridgely W., 306-C West College Terrace, Frederick, Md.
Baxter, J. Murray, 4 E. Church Street, Frederick, Md.
Beall, Ira W., Libertytown, Md.
Belt, Norvell, Professional Building, Frederick, Md.
Birely, Morris F., Thurmont, Md.
Blundell, George P., P.O. Box 179, Braddock Heights, Md.
Bourne, U. G., Jr., 30 W. All Saints Street, Frederick, Md.
§Brice, Arthur T., Jefferson, Md.
Brinkley, G. Ross, Jr., 116 W. Church Street, Frederick, Md.
Burgess, Forbes H., Winchester Hall, Frederick, Md.
Cadle, W. R., Emmittsburg, Md.
Chase, Henry V., 4 E. Church Street, Frederick, Md.
Conley, Charles H., Jr., Professional Building, Frederick, Md.
Crouch, Robert D., 101 Office Building, Shopping Center, Frederick, Md.
Culler, John M., 15 E. Second Street, Frederick, Md.
Damazo, Frank S., Jr., 420 Sherman Avenue, Frederick, Md.
Derr, John S., 35 E. Church Street, Frederick, Md.
Dettbarn, Ernest, Walkersville, Md.
Fahrney, H. Laurence, 17 E. Second Street, Frederick, Md.
Fifer, Jesse S., 35 E. Church Street, Frederick, Md.
Fruth, Richard L., 7 Linden Avenue, Frederick, Md.
Furie, Robert J., R.F.D. #6, Frederick, Md.
Gray, H. W., 35 E. Church Street, Frederick, Md.
Gray, James K., Thurmont, Md.
Guest, Russell L., 7 E. Church Street, Frederick, Md.
Harp, Jacob E., Middletown, Md.
§Heldrich, Frederick J., Jr., 220 N. Market Street, Frederick, Md.
Henson, Kenneth C., 208 Broad Street, Middletown, Md.
Kadull, Paul J., Fort Detrick, Frederick, Md.
Kao, Chin Toi B., 15 S. Maryland Avenue, Brunswick, Md.
Kline, Horace F., 7 N. Market Street, Frederick, Md.
§Lansdale, P. S., 35 E. Church Street, Frederick, Md.
Lea, Melvin E., 35 E. Church Street, Frederick, Md.
Lerner, Joseph, Riggs Cottage Sanitorium, Ijamsville, Md.
Martin, Rex, East Church Street, Frederick, Md.
Michels, Ralph L., New Market, Md.
§Pearre, A. Austin, 4 E. Church Street, Frederick, Md.
Pilgram, Robert H., Professional Building, Frederick, Md.
Powell, Albert M., Jr., 220 N. Market Street, Frederick, Md.
Pruitt, Charles, Brunswick, Md.
Quill, Thomas H., Professional Building, Frederick, Md.
§Reid, Thomas, Professional Building, Frederick, Md.
Schoolman, Louis Robert, Professional Building, Frederick, Md.
Slusher, Hamilton J., 7 E. Church Street, Frederick, Md.
Smith, J. G. F., Brunswick, Md.
Smith, W. M., Frederick, Md.
Stone, Thomas E., Braddock Heights, Md.
Stoner, James E., Jr., Walkersville, Md.
Tannenbaum, Karl H., 8 E. Second Street, Frederick, Md.
Thomas, Bernard O., Professional Building, Frederick, Md.
Thomas, Bernard O., Jr., Professional Building, Frederick, Md.
Thomas, Edward P., 4 E. Church Street, Frederick, Md.
Thomas, James B., Professional Building, Frederick, Md.
Turner, Robert S., Jr., 7 E. Church Street, Frederick, Md.
§White, Byron D., 35 E. Church Street, Frederick, Md.
Williams, Charles R., 106 E. Main Street, Emmitsburg, Md.
Worthington, Frank D., Professional Building, Frederick, Md.

Harford County

Barthel, Robert A., Jr., Forest Hill, Md.
§Brendle, William K., 608 S. Union Avenue, Havre de Grace, Md.
§Councill, Wilford A. H., Jr., 9 E. Mount Royal Avenue, Baltimore 2, Md.
Dorogi, Benjamin, Cardiff, Md.
Finney, James McC., 330 S. Union Avenue, Havre de Grace, Md.
*Foley, Charles J., Havre de Grace, Md.
Follweiler, Robert A., 226 N. Union Avenue, Havre de Grace, Md.
§Gordon, Neil, Health Department, 119 Hays Street, Bel Air, Md.
Hatem, Frederick J., 17 N. Philadelphia Boulevard, Aberdeen, Md.
Heuman, Philip W., Hickory Avenue, Bel Air, Md.
Hirsch, Gunther D., 421 Congress Avenue, Havre de Grace, Md.
Hodous, Frederick, Edgewood, Md.
§Horky, J. Ralph, Churchville, Md.
Hudson, Willard P., Forest Hill, Md.
Kaiser, Theodore H., 419 S. Union Avenue, Havre de Grace, Md.
Lewis, Addison Leroy, 214 N. Union Avenue, Havre de Grace, Md.
Loo, Edward C., 211 N. Union Avenue, Havre de Grace, Md.
McGreevy, Joan F., Nina Avenue, Meadowvale Manor, Havre de Grace, Md.
Norment, Richard, III, 602 South Union Avenue, Havre de Grace, Md.
Palmer, Gerald C., 211 S. Main Street, Bel Air, Md.

* Deceased.
§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

Phillips, Malcolm Dudley, Darlington, Md.
Plunkett, Barry J., Jr., 617 W. Belair Avenue, Aberdeen, Md.
Rodman, Peter P., P. O. Box 441, Aberdeen, Md.
Ross, Irvin R., 200 Union Avenue, Havre de Grace, Md.
Sandecki, Alexander, 15 Courtland Street, Bel Air, Md.
Sidwell, Harvey P., 138 N. Main Street, Bel Air, Md.
Simon, Edward J., 123 S. Union Avenue, Havre de Grace, Md.
§Snodgrass, Frank, Darlington, Md.
Stansbury, George, 569 Revolution Street, Havre de Grace, Md.
Stewart, Charles W., Jr., 1 Cedar Street, Edgewood, Md.
Stonesifer, Paul, 115 Fulford Avenue, Bel Air, Md.
Thomison, Samuel J., Jr., Jarrettsville, Md.
Tyson, William A., Kingsville, Md.
Wachsman, Irvin L., Union Avenue and Franklin Street, Havre de Grace, Md.
Weiss, Andre, 17 N. Philadelphia Blvd., Aberdeen, Md.
Wolbert, Frank, Havre de Grace, Md.

Howard County

Brumbaugh, B. Bruce, Elkridge, Md.
Burgtorf, George E., Jr., Ellicott City, Md.
Fisher, Donald E., 101 Columbia Road, Ellicott City, Md.
§Groleau, George E., Elkridge, Md.
Phillips, Frederick E., 2500 Eutaw Place, Baltimore 17, Md.
Shipley, Frank E., Savage, Md.
Shrop, Theodore R., State Department of Health, Ellicott City, Md.
§Taylor, Irving J., Ellicott City, Md.
Thorpe, Peter V., Columbia Road, Ellicott City, Md.
Whitaker, Charles Stanley, Clarksville, Md.

Kent County

Brice, Merritt, % Wm. T. Brice, Arcadia Farm, R.D. #3, Chestertown, Md.
Dick, A. C., Chestertown, Md.
Farr, Robert W., Chestertown, Md.
Gerstley, Manfred J., Chestertown, Md.
§Gulbrandsen, Oskar, 6810 Blenheim Road, Apt. D, Baltimore 12, Md.
§Hamilton, H. H., Millington, Md.
Joyce, Florence D., Worton, Md.
Keefe, Arthur T., Jr., Chestertown, Md.
Kester, Eugene, Rock Hall, Md.
Koralewski, Geza, Millington, Md.
Nitsch, N. C., Rock Hall, Md.
Solon, Thomas, Chestertown, Md.
§Whitsitt, A. F., Chestertown, Md.

Montgomery County

Adland, Marvin L., 5521 Uppingham Street, Chevy Chase 15, Md.
§Allen, Samuel, 10407 Fawcett Street, Kensington, Md.
§Andren, Henry E., 7600 Carroll Avenue, Takoma Park, Md.
Andrews, John N., 9601 Colesville Road, Silver Spring, Md.
§Andrews, Peter P., 4761 Bradley Boulevard, Chevy Chase 15, Md.
§Angle, Robert G., 5009 Del Ray Avenue, Bethesda, Md.
§Arnold, Russell, 7807 Cole Avenue, Takoma Park, Md.
§Aud, William D., 9006 Colesville Road, Silver Spring, Md.
Auld, Richard McG., 809 Viers Mill Road, Rockville, Md.
Avery, John Lawrence, 10110 Georgia Avenue, Silver Spring, Md.
Baernstein, Laura N., 4611 Highland Avenue, Bethesda, Md.
Bajda, Lenore A. J. R., Montgomery County Health Department, Rockville, Md.
§Ball, John G., 7936 Old Georgetown Road, Bethesda 14, Md.
§Bankhead, J. Marion, 9241 Columbia Boulevard, Silver Spring, Md.
Barr, J. F., 9804 Dilston Road, Silver Spring, Md.
Barrett, B. Irene, 8015 Old Georgetown Road, Bethesda 14, Md.
Beardsley, O. Bennet, 7600 Carroll Avenue, Takoma Park, Washington 12, D.C.
Beeman, Edward A., 10620 Georgia Avenue., Silver Spring, Md.
Bernton, Horace W., 10511 Summit Avenue, Kensington, Md.
§Bier, Robert A., 9028 Woodland Drive, Silver Spring, Md.
§Bird, J. W., Sandy Spring, Md.
Black, Emilie Annabelle, 5000 Alta Vista Road, Bethesda 14, Md.
Blunden-Morris, Dulcie, 306 Patterson Court, Takoma Park, Md.
§Bonifant, Dement, Sandy Springs, Md.
§Boyer, M. McKendree, Damascus, Md.
Bradshaw, Raymond, 10331 Old Bladensburg Road, Silver Spring, Md.
§Brady, John B., 927 Pershing Drive, Silver Spring, Md.
§Brennan, Andrew J., 5715 Aberdeen Road, Bethesda, Md.
Brewer, Robert G., 8218 Wisconsin Avenue, Bethesda 14, Md.
Broschart, F. J., 8 Russel Avenue, Gaithersburg, Md.
§Brown, Crawford, 8218 Wisconsin Avenue, Bethesda 14, Md.
Brownsberger, John F., Washington Sanitarium, Takoma Park, Md.
§Buckley, Michael L., 4630 Montgomery Avenue, Bethesda 14, Md.
§Bullard, Dexter M., Chestnut Lodge, Inc., Rockville, Md.
Burnham, Donald Love, 500 W. Montgomery Avenue, Rockville, Md.
Buxton, Rex, 5202 Western Avenue, Bethesda, Md.
Calvert, Read N., 7894 Georgia Avenue, Silver Spring, Md.
Canney, Philip C., Box 2, Dept. of Anesthesia, Letterman Army Hospital, San Francisco, Calif.
Carbo, R. J., 809 Viers Mill Road, % Medical Center, Rockville, Md.
Cassidy, John E., 9911 Old Georgetown Road, Bethesda, Md.
§Caylor, Claude, 10312 Colesville Road, Silver Spring, Md.
Chapman, Katharine A., 3924 Baltimore Street, Kensington, Md.
Christensen, Gilbert R., 7912 Lockney Avenue, Takoma Park, Md.
§Coale, Robert N., 8707 Cranbrook Court, Bethesda, Md.
§Cochran, Winston, 927 Pershing Drive, Silver Spring, Md.
Cohen, Abe M., 7961 Eastern Avenue, Silver Spring, Md.
Cohen, George J., 9919 Georgia Avenue, Silver Spring, Md.

§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

§Cohen, Maynard I., 2412 Colston Drive, Silver Spring, Md.
§Cohen, Ralph, 11441 Old Bladensburg Road, Suite 2, Second Floor, Wheaton, Md.
§Conley, John R., 3716 Howard Avenue, Kensington, Md.
§Connor Joseph, 9600 Old Georgetown Road, Bethesda, Md.
Cook, Thomas A., Jr., 10620 Georgia Avenue, Silver Spring, Md.
Cooper, Corinne, 104 S. Washington Street, Rockville, Md.
Coyne, Arthur E., Washington Sanitarium & Hospital, Takoma Park, Md.
Cromwell, Stephen C., 615 W. Montgomery Avenue, Rockville, Md.
§Cross, Merrill M., 8248 Georgia Avenue, Silver Spring, Md.
Cullander, Cecil C. H., 7804 Fairfax Road, Bethesda 14, Md.
§Curry, John J., 11301 Georgia Avenue, Silver Spring, Md.
Curtis, Leo M., 8218 Wisconsin Avenue, Bethesda 14, Md.
Cushard, William G., 3201 Leland Street, Chevy Chase, Md.
Cuvillier, L. Marshall, Jr., 1407 Woodside Parkway, Silver Spring, Md.
§Danish, Abraham W., 927 Pershing Drive, Silver Spring, Md.
§De Lawter, De Witt E., 8025 Aberdeen Road, Bethesda 14, Md.
§Diamond, Herbert H., 8224 Georgia Avenue, Silver Spring, Md.
Dick, Delbert R., 8005 Glenside Drive, Takoma Park, Washington 12, D. C.
§Dietz, Leonard L., 929 Pershing Drive, Silver Spring, Md.
§Diley, Russell B., 8218 Wisconsin Avenue, Bethesda 14, Md.
§Dobridge, Michael R., 1421 Crestridge Drive, Silver Spring, Md.
Donovan, Leo I., 8016 Old Georgetown Road, Bethesda, Md.
Dyrud, Jarl E., 5703 Warwick Place, Chevy Chase 15, Md.
§Eastman, W. W., 8700 Colesville Road, Silver Spring, Md.
§Edison, Thomas, 925 Pershing Drive, Silver Spring, Md.
§Egan, James W., 7720 Wisconsin Avenue, Bethesda 14, Md.
Ehrmantraut, Wilford R., 4890 Battery Lane, Bethesda 14, Md.
Eig, Blaine H., 8641 Colesville Road, Silver Spring, Md.
§Ekman, Donald Q., 5707 Wisconsin Avenue, Chevy Chase, Md.
§Everding, Charles J., 6710 Hillandale Road, Chevy Chase 15, Md.
Farwell, Charles, 12126 Viers Mill Road, Wheaton, Md.
§Fawcett, John, Dawsonville, Md.
§Fearing, John M., 35 Quincy Street, Chevy Chase, Md.
Felix, Robert H., (Asso.), National Institutes of Mental Health, Bethesda, Md.
Fisher, Richard, 1801 Eye Street, N.W., Washington, D. C.
§Fitzgerald, Bernard A., 9620 Old Bladenburg Road, Silver Spring, Md.
Fitzgerald, James Blaine, 8218 Wisconsin Avenue, Bethesda Medical Building, Bethesda 14, Md.
§Flaiz, Theodore R., 6840 Eastern Avenue, N.W., Washington, D.C.
Fort, John P., 500 W. Montgomery Avenue, Rockville, Md.
Fox, Mary A., 7400 Fairfax Road, Bethesda 14, Md.
Geiger, Jason, 931 Pershing Drive, Silver Spring, Md.
Gibson, Robert W., 500 W. Montgomery Avenue, Rockville, Md.
Gill, Dorothy, 7511 Arlington Road, Bethesda 14, Md.
Gill, Grover B., 4601 Doset Avenue, Chevy Chase 15, Md.
§Glick, Herbert D., 8301 Piney Branch Road, Silver Spring, Md.
Glover, Sarah E., 4208 Anthony Street, Kensington, Md.
§Gray, George A., Jr., 104 Chevy Chase Drive, Chevy Chase, Md.
Greenberg, Harold A., 403 Ritchie Parkway, Rockville, Md.
Greenberg, Robert M., 2310 Washington Avenue, Washington 5, D. C.
§Haberlin, John P., 927 Pershing Drive, Silver Spring, Md.
Hall, W. G., 615 W. Montgomery Avenue, Rockville, Md.
§Hardy, Cyril G., 8913 Georgia Avenue, Silver Spring, Md.
§Hare, Robert A., Washington Sanitarium & Hospital, Takoma Park, Md.
Harmon, Ernest E., 9301 Colesville Road, Silver Spring, Md.
Hebert, Clarence L., 9429 Locust Hill Road, Bethesda 14, Md.
§Hindman, Thomas A. N., 3935 Baltimore Street, Kensington, Md.
Hornibrook, John W., National Institutes of Health, Bethesda, Md.
Huff, Wheeler O., 4529 Maple Avenue, Bethesda, Md.
§Hughes, Charles R., Suite 215, 8226 Fenton Street, Silver Spring, Md.
Hughes, Emma, Washington Sanitarium & Hospital, Takoma Park, Md.
§Hunter, G. Bowditch, 809 Viers Mill Road, Rockville Medical Center, Rockville, Md.
Inwood, Eugene, 5209 Worthington Drive, Washington, D. C.
Jackson, Clive E., Route #1, Gaithersburg, Md.
§Jacobs, Herbert J., 10620 Georgia Avenue, Silver Spring, Md.
§Jaeger, Henry W., 925 Pershing Drive, Silver Spring, Md.
Jaffe, Vita, 6301 W. Holbert Road, Bethesda, Md.
§Jaggers, Frank Y., 5707 Wisconsin Avenue, Chevy Chase, Md.
Jarvis, Marjorie, 100 Park Street, Rockville, Md.
§Johnson, Linwood H., 104 Chevy Chase Drive, Chevy Chase 15, Md.
Jones, Philip Edward, 918 Ellsworth Drive, Silver Spring, Md.
§Jones, Stephen Noland, 809 Vier Mill Road, % Medical Center, Rockville, Md.
§Joyce, William T., 8106 Maple Ridge Road, Bethesda 14, Md.
Kasle, Travis, 4820 Cumberland Avenue, Chevy Chase 15, Md.
Kenrick, Joseph P., 6450 Wisconsin Avenue, Chevy Chase, Md.
§Kerr, James P., Damascus, Md.
Killay, William H., Jr., 5723 Bradley Boulevard, Bethesda 15, Md.
§Kimble, J. Norman, Washington Sanitarium & Hospital, Washington 12, D. C.
Kimble, Seruch Titus, 929 Pershing Drive, Silver Spring, Md.
Kluger, J. A., 1908 August Drive, Silver Spring, Md.
Kortis, Howard I., 7704 Colesville Road, W. Hyattsville, Md.

§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

*Kress, Daniel H., 405 Niblic Avenue, Orlando, Fla.
*Kress, Lauretta, 405 Niblic Avenue, Orlando, Fla.
Kroutil, Ludwig C., 918 Ellsworth Drive, Silver Spring, Md.
Kroutil, Persis M., 918 Ellsworth Drive, Silver Spring, Md.
Landman, Manuel P., (Asso.), 216 Dearborn Avenue, Silver Spring, Md.
Lang, Louis R., 8641 Colesville Road, Silver Spring, Md.
Lauer, David P., 5071 Bradley Boulevard, Chevy Chase 15, Md.
§Laughlin, Henry P., 6800 Hillcrest Place, Chevy Chase, Md.
§Laughlin, Kenneth F., 934 Ellsworth Drive, Washington Building, Silver Spring, Md.
§Leal, L. I., 108 N. Frederick Avenue, Gaithersburg, Md.
§Leventhal, Sydney, 9210 Colesville Road, Silver Spring, Md.
§Lewis, Edward, Jr., 5800 Beach Avenue, Bethesda 14, Md.
§Ligon, Charles H., Sandy Spring, Md.
Linthicum, William A., 110 S. Washington Street, Rockville, Md.
Lombard, Peter N., 1017 Woodside Parkway, Silver Spring, Md.
Lorenz, Elmer W., Washington Sanitarium, Takoma Park, Md.
Lucius, Naomi T., 9321 Georgia Avenue, Silver Spring, Md.
§McCarrick, James P., 809 Viers Mill Road, ℅ Medical Center, Rockville, Md.
McCune, Wallace H., Suite 215, 8226 Fenton Street, Silver Spring, Md.
McDonald, Audrey J., 3726 Manor Road, Apt. #3, Chevy Chase 15, Md.
McDonald, Mildred, 1610 N. Springwood Drive, Silver Spring, Md.
§McGarry, Edward C., 6400 Winston Drive, Bethesda 14, Md.
§McLeod, John H., 9400 Old Georgetown Road, Bethesda 14, Md.
§McNeill, Willard P., Star Route, Spencerville, Md.
Maganzini, Herman C., 809 Viers Mill Road, Rockville, Md.
Magi, Eino, 918 University Boulevard, East, Silver Spring, Md.
Mahler, Paula E., 5311 Roosevelt Street, Bethesda 14, Md.
Martinez, F. A., 4630 Montgomery Avenue, Bethesda, Md.
Mattern, Elizabeth A., 35 Northampton Avenue, Berkeley 7, Calif.
Maxwell, George A., 121 S. Washington Street, Rockville, Md.
§Meadors, Gilcin, Damascus, Md.
Meng, Ralph H., 304 Chevy Chase Center Building, 35 Wisconsin Circle, Chevy Chase 15, Md.
Miller, William C., 7 Brooks Avenue, Gaithersburg, Md.
Mitchell, Claude W., 818 Bonifant Street, Silver Spring, Md.
§Mitchell, Harold H., R.F.D. #2, Gaithersburg, Md.
Mitchell, Reginald H., 8218 Wisconsin Avenue, #204, Bethesda 14, Md.
§Mones, Marvin I., 927 Pershing Drive, Silver Spring, Md.
Mook, Wallace N., 7701 Carroll Avenue, Takoma Park, Md.
§Morris, Gary Owens, 7942 Wisconsin Avenue, Bethesda, Md.
§Morse, Howard T., 7030 Carroll Avenue, Takoma Park, Md.
Moulton, Barbara, 5132 Bradley Boulevard, Bethesda 14, Md.
Moxness, Bennie A., 4903 Chevy Chase Boulevard, Chevy Chase, Md.
Murgolo, V. John, 734 Ellsworth Drive, Silver Spring, Md.
Murphy, William S., 615 W. Montgomery Avenue, Rockville, Md.
Myers, Richard C., 8512 Old Georgetown Road, Bethesda 14, Md.
Naples, Carmon R., Suite 72, Parkwood Medical Building, 1746 K. Street, N.W., Washington 6, D.C.
Norton, Alfred S., 4711 Highland Avenue, Bethesda, Md.
Nosphitz, Joseph D., 3014 Que Street, N.W., Washington 7, D.C.
O'Donnell, Vincent L., 8212 Wisconsin Avenue, Bethesda 14, Md.
§Oliver, Norman, 1108 Woodside Parkway, Silver Spring, Md.
§O'Neil, Joseph M., 809 Viers Mill Road, Rockville, Md.
O'Neill, Allen J., 8601 Old Georgetown Road, Bethesda 14, Md.
§Ostmann, Francis, 8035 - 13th Street, Silver Spring, Md.
Ostrow, Bernard, 7691 Eastern Avenue, Silver Spring, Md.
Patrick, George B., Jr., 8700 Colesville Road, Silver Spring, Md.
Patten, Ralph F., 8641 Colesville Road, Suite 418, Silver Spring, Md.
Paul, Leo J., 3220 Riverside Avenue, Muncie, Ind.
§Pearlman, Ira W., 4700 Bradley Boulevard, Chevy Chase 15, Md.
Peeples, Margaret O., Route 2, Rockville, Md.
Peeples, William J., Montgomery Health Department, Rockville, Md.
§Perry, Morris, 11602 Georgia Avenue, Silver Spring, Md.
Pincock, Carolyn, 1944 Seminary Road, Silver Spring, Md.
Porter, Bennett A., Jr., 9500 St. Andrews Way, Silver Spring, Md.
Price, Florence R., 4615 Edgefield Road, Parkwood, Bethesda, Md.
Price, Vincent E., 4615 Edgefield Road, Parkwood, Bethesda, Md.
§Queen, G. Burton, 7112 Willow Avenue, Takoma Park, Md.
Richwine, Alfred H., 5522 Western Avenue, Chevy Chase, Md.
Rintz, Norman C., 4701 Bradley Boulevard, Apt. 104, Bethesda 14, Md.
§Robben, John O., 7930 Georgia Avenue, Silver Spring, Md.
§Roberts, James A., 8907 Georgia Avenue, Silver Spring, Md.
Robin, Bennett A., 8723 Piney Branch Road, Silver Spring, Md.
Robinson, Murray M., Farragut Medical Building, Washington, D.C.
Rogers, John S., 1009 Seminary Road, Silver Spring, Md.
§Rohrbaugh, Austin B., Jr., 104 Chevy Chase Drive, Chevy Chase, Md.
Rosenberger, Gordon, 26 N. Summit Avenue, Gaithersburg, Md.
St. Martin, David A., 10620 Georgia Avenue, Silver Spring, Md.
§Santucci, Peter, 8218 Wisconsin Avenue, Suite 305, Bethesda, Md.
§Savarese, Charles J., Jr., 4890 Battery Lane, Bethesda 14, Md.

* Deceased.
§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty

Scharfenberg, John A., Building 16A, National Institutes of Health, Bethesda 14, Md.
§Schilt, Clarence H., Silver Spring Medical Building, 10620 Georgia Avenue, Silver Spring, Md.
Schipper, Gerald J., 12505 Washington Avenue, Spring Lake Park, Rockville, Md.
§Schnebly, J. Thomas, 11134 Georgia Avenue, Silver Spring, Md.
Schoenfeld, Herbert H., 4325 - 49th Street, N.W., Washington 16, D.C.
Schultz, George N., 9514 Colesville Road, Silver Spring, Md.
§Schumacher, Jack, 105 Russell Avenue, Gaithersburg, Md.
Sewell, Webster, Norbeck R.F.D. 1, Silver Spring, Md.
Sharpe, George, 10511 Summit Avenue, Kensington, Md.
Sherman, Robert J., 5001 Hurst Terrace, N.W., Washington, D.C.
§Shoemaker, Norman C., 8005 Woodbury Drive, Silver Spring, Md.
Silverman, Carl, 12801 Evanston Street, Rockville, Md.
§Smith, Gordon M., Barnesville, Md.
Snow, Lee B., 9013 Flower Avenue, Silver Spring, Md.
Snow, Margaret, 9013 Flower Avenue, Silver Spring, Md.
§Spence, George R., 1515 Highland Drive, Silver Spring, Md.
Standard, Ruth, Washington Sanitorium & Hospital, Takoma Park, Md.
Starr, Paul V., Washington Sanitarium, Takoma Park, Md.
Stiller, Ralph, 11812 Ivanhoe Street, Wheaton, Md.
§Stout, Henry, 10011 Georgia Avenue, Silver Spring, Md.
Szebehely, Eva N., Suburban Hospital, Bethesda, Md.
Tamagna, Irene G., 7101 Connecticut Avenue, Chevy Chase 15, Md.
Tenenblatt, Sarah S., 12817 Lacy Drive, Silver Spring, Md.
Tenenblatt, William, 10620 Georgia Avenue, Silver Spring, Md.
Terry, Luther L., Clinical Center, National Heart Institute, Bethesda 14, Md.
§Thibadeau, Andrew F., 10111 Colesville Road, Silver Spring, Md.
Thibadeau, Richard B., Cedar Craft Sanitarium, Silver Spring, Md.
§Thibadeau, Robert T., 10609 Concord Street, Kensington, Md.
Thompson, Oliver E., 901 Pershing Drive, Silver Spring, Md.
Traum, Aaron H., 8237 Georgia Avenue, Silver Spring, Md.
Troendle, Francis J., 809 Viers Mill Road, Rockville, Md.
Troost, Veronica, 10401 New Hampshire Avenue, Silver Spring, Md.
§Tuohy, John, National Institutes of Health, Bethesda, Md.
Varner, Philip H., 7702 Connecticut Avenue, Chevy Chase, Md.
Varney, Hewitt I., 5904 Connecticut Avenue, Chevy Chase 15, Md.
§Vinten-Johansen, Ejnar, 7105 Wilson Lane, Bethesda 14, Md.
Vuitch, Milan M., 8204 Grubb Road, Chevy Chase 15, Md.
Wardrop, W. B., 837 Bonifant Street, Silver Spring, Md.
Warfield, Charles I., 8035 13th Street, Silver Spring, Md.
§Warthen, Robert O., 3716 Howard Avenue, Kensington, Md.
§Weber, Charles M., 10620 Georgia Avenue, Silver Spring, Md.
Weigert, Edith V., 12 Oxford Street, Chevy Chase 15, Md.
White, Merton L., 11134 Georgia Avenue, Silver Spring, Md.
§White, Roland H., 918 Ellsworth Drive, Silver Spring, Md.
Whitlock, James M., 7701 Carroll Avenue, Takoma Park 12, Md.
Wilets, Arthur J., 909 Pershing Drive, Silver Spring, Md.
§Williams, Lysle W., 8700 Colesville Road, Silver Spring, Md.
Witowski, Edward S., 5606 Massachusetts Avenue, Ext., Washington 16, D. C.
Wolf, Stanley I., 2322 Blue Ridge Avenue, Wheaton, Md.
Woodward, Arthur, 41 West Wood Lane, Rockville, Md.
§Yates, Richard, Box 127, Olney, Md.
Yuen, Lilu, 3422 Brown Street, N. W., Washington 10, D. C.
Ziegler, John B., Olney, Md.
Zung, Max M., 7904 Rocton Avenue, Chevy Chase 15, Md.

Prince George's County

§Altman, Harry E., 1363 Underwood Street, N.W., Washington, D. C.
§Bachrach, Louis B., 915-19th Street, N.W., Washington, D. C.
Bauer, Richard D., 4314 Gallatin Street, Hyattsville, Md.
§Bayly, John H., 1835 Eye Street, N.W., Washington 6, D. C.
§Bergeman, Till, 3 D Crescent Street, Greenbelt, Md.
Bloemsma, Philip, 5911-16th Street, N.W., Washington 11, D. C.
Bloomberg, Max, 30 D Ridge Road, Greenbelt, Md.
Bogaert, Conrado, 2324 Iverson Street, S.E., Hill Crest Height, Md.
Bosworth, Robert J., 811-8th Street, N.E., Washington 2, D.C.
Boyd, James Irving, 8200 Marlboro Pike, S.E., Washington, D. C.
Brady, Z. M., 6715 Roosevelt Street, Seat Pleasant, Md.
§Brainin, William, 6124 Central Street, Capitol Heights, Md.
Brown, Leo T., 1621 New Hampshire Avenue, N.W., Washington, D. C.
Buell, John R., Jr., 402 Main Street, Laurel, Md.
Bunge, William R., U. S. Army Dispensary, Ft. Myer, Arlington 11, Va.
Burns, Cornelius J., Prince George's General Hospital, Cheverly, Md.
Campbell, Kenneth D., 9705 R. I. Avenue, College Park, Md.
*Chase, William W., 915-19th Street, N.W., Washington, D. C.
Chen, Paul T. C., Accokeek, Md.
§Christensen, Thomas A., 6905 Baltimore Boulevard, College Park, Md.
Christman, Claire A., 9703 Riggs Road, Adelphi, Md.
§Clayman, David S., 6311 Baltimore Avenue, Riverdale, Md.
Clements, William H., 6001-35th Avenue, Hyattsville, Md.
Clum, John P., 6110-43rd Avenue, Hyattsville, Md.
Coggins, Jesse C., Laurel, Md.
§Comeau, Norman D., 3303 Perry Street, Mt. Rainier, Md.

* Deceased.
§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

Cox, Oliver C., 3115 Nebraska Avenue, N.W., Washington, D. C.
D'Angelo, John P., 4223 Silver Hill Road, S.E., Washington 20, D. C.
§Deitz, Aaron, 4314 Gallatin Street, Hyattsville, Md.
Diamond, Leopold, 3501 Kayson Street, Silver Spring, Md.
§Dixon, William M., Prince George's General Hospital, Cheverly, Md.
Dodd, Elbert W., Jr., 2812 Crest Avenue, Cheverly, Md.
Duus, Peter, 6124 Central Avenue, Capitol Heights, Md.
Edlow, Jules B., 2500 Wisconsin Avenue, N.W., Washington 7, D. C.
Eisenberg, Herman, 6480 New Hampshire Avenue, Takoma Park, Md.
§Eisner, William, 30 B Ridge Road, Greenbelt, Md.
§Etienne, Wolcott L., 4713 Berwyn Road, College Park, Md.
§Ferris, Harry E., 4415 Queensbury Road, Riverdale, Md.
§Fleischer, Ronald S., Hamilton Manor Apartments, 5432 Queens Chapel Road, Hyattsville, Md.
§Fogel, Julius, 1726 M. Street, N.W., Washington, D. C.
§Gallin, Leon L., 7206 Colesville Road, West Hyattsville, Md.
Gibson, Walcutt W., 5408 Henderson Road, Washington 22, D. C.
Gilbert, Jules, 3200 Chilien Road, Mt. Rainier, Md.
Glickfield, H. Wayne, 6826 Riggs Road, Hyattsville, Md.
Gordon, David S., 5731-23rd. Parkway, Hillcrest Heights, Md.
Graeff, Earl W., 2716 Kirkwood Place, W. Hyattsville, Md.
Grassgreen, Irvin M., 3101 Arundel Road, Mt. Rainier, Md.
Gray, H. William, 7009 Marlboro Pike, District Heights, Md.
§Hagan, William B., 3303 Perry Street, Mt. Rainier, Md.
§Hageage, Charles C., 3308 Perry Street, Mt. Rainier, Md.
§Hageage, George J., 3717 38th Avenue, Cottage City, Md.
§Haught, John S., 3303 Perry Street, Mt. Rainier, Md.
Hays, Leonard, 5201 Baltimore Avenue, Hyattsville, Md.
§Herzberg, Max, 7016 Greig Street, Seat Pleasant, Md.
Holahan, Gordon V., 7720 Wisconsin Avenue, Bethesda, Md.
§Holbrook, William A., Jr., 4500 College Avenue, College Park, Md.
§Hughes, Lloyd W., 4605 Fordham Road, College Park, Maryland
§Hutchins, Thomas M., 2716 Bellview Avenue, Cheverly, Md.
Jimal, Louis M., 4008 Bladensburg Road, Cottage City, Md.
§Kauffman, Julius, 5102 Annapolis Road, Bladensburg, Md.
§Kehoe, John, 3403 Cheverly Avenue, Cheverly, Md.
§Kelly, Gordon W., 6124 41st Avenue, Hyattsville, Md.
Kolega, Bruno, 7290 Marlboro Pike, S.E., Washington, D. C.
Kenmore, Peter I., 4314 Gallatin Street, Hyattsville, Md.
Kolkin, M. L., 1615 Tilton Drive, Silver Spring, Md.
Kurz, William J., 6409 Colesville Road, Hyattsville, Md.
Lane, Edwin C., 5664 Livingston Road, Oxon Hill, Md.
Lapin, Alfred R., Clinton Medical Center, Clinton, Md.
Laubach, James L., 1806 Fox Street, Hyattsville, Md.
Lavine, Harold, 5802 Baltimore Avenue, Hyattsville, Md.
§Lavine, Oscar, 4101 Underwood Street, Hyattsville, Md.
§Lear, Arnold A., 6114 Westland Drive, Hyattsville, Md.
Leonarduzzi, David R., 2901 Fairlawn, Hillcrest Heights, Md.
Levitsky, Leon, 4300 Kaywood Drive, Mt. Rainier, Md.
Lowry, S. W., 7601 Gateway Boulevard, Washington 28, D. C.
Lynn, J. T., 5241 St. Barnabas Road, S.E., Washington, D. C.
§McCeney, Robert S., 402 Main Street, Laurel, Md.
*McDonnell, Henry B., 7400 Dartmouth Street, College Park, Md.
McDonald, Joseph J., 7309 Riggs Road, W. Hyattsville, Md.
McLain, George H., 1746 K. Street, N.W., Washington, D. C.
Malin, Lawrence White, 4404 Queensbury Road, Riverdale, Md.
Maloney, Thomas G., Jr., 4814 71st Avenue, Landover Hills, Md.
Mandes, James C., 3408 Rhode Island Avenue, Mt. Rainier, Md.
Marans, Allen E., 1017 University Boulevard, East Langley Park, Md.
§Mendel, C. Louis, 4506 College Avenue, College Park, Md.
§Miller, Benjamin S., 3824 Thirty-fourth Street, Mt. Rainier, Md.
Mock, Ernest L., 4212-29th Street, Mt. Rainier, Md.
Modlin, Albert J., 388 Montrose Avenue, Laurel, Md.
§Moody, Louis H., Jr., 4610 Clemson Road, College Park, Md.
§Moyers, Waldo B., 6901 Pineway, Hyattsville, Md.
§Musser, Frederick, 5716 Jason Street, Cheverly, Md.
Neviaser, Julius, 1918 "K" Street, N.W., Washington, D. C.
Parent, Ernest J., 6220 Ager Road, Green Meadows, West Hyattsville, Md.
§Paul, Murray, 1901 Erie Street, Apt. 103, Hyattsville, Md.
Peacock, Bernard F., 2707 Kenton Place, Hill Crest Heights, Md.
§Perkins, John W., 5301 Hamilton Street, Hyattsville, Md.
Philpott, William H., 6480 New Hampshire Avenue, Takoma Park, Md.
Piver, Julius S., 6480 New Hampshire Avenue, Takoma Park, Md.
Purdie, Donald R., 4404 Queensbury Road, Riverdale, Md.
Rabkin, Boris, 8102 University Lane, Silver Spring, Md.
Read, James, 4500 College Avenue, College Park, Md.
§Reilly, Robert R., 108 Sea Girt Avenue, Sea Girt, N. J.
Ritchie, W. S., 7005 Ritchie Road, S.E., Washington 27, D. C.
Rosson, William D., 5304 Annapolis Road, Bladensburg, Md.
§Roth, Albert, 5510 Madison Street, Riverdale, Md.
Sarao, E. A., 7006 N. H. Avenue, Takoma Park, Md.
Sartwell, Mary K. L., 6811 Riggs Road, W. Hyattsville, Md.
§Sasscer, James G., Box 268, Upper Marlboro, Md.

* Deceased.
§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

Sasscer, Robert, Upper Marlboro, Md.
Schnitzer, W. F., Second National Bank Building, Ashland, Ky.
§Schwartzbach, Saul, 1726 Eye Street, N.W., Washington, D. C.
Seron, Vaheh M., Aquasco, Md.
Shaver, Arthur, Jr., Branch Avenue at Woodyard Road, Clinton, Md.
§Skipton, Roy K., 4500 College Avenue, College Park, Md.
§Stecher, William, 11506 Michale Court, Silver Spring, Md.
Steward, N. B., 314 Compton Avenue, Laurel, Md.
§Sugar, S. Jack, 5802 Baltimore Avenue, Hyattsville, Md.
§Sugar, Samuel J. N., 4300 Kaywood Gardens, Mt. Rainier, Md.
§Suraci, Alfred, 915 19th Street, N.W., Washington 6, D. C.
Szollosi, Etienne, 2 Parkway Drive, Forest Heights, Washington 21, D. C.
Tidler, Harold S., 6480 New Hampshire Avenue, Takoma Park, Md.
Ulshafer, Thomas R., LCDR, MC, USN, National Naval Medical Center, Bethesda, Md.
§Van Natta, Paul C., 5440 Silver Hill Road, Parkland, Md.
§Ware, George W., 900-17th Street, N.W., Washington, D. C.
§Warren, B. P., 305-7 Prince George Street, Laurel, Md.
§Warren, J. Francis, 2015 R Street, N.W., Washington, D. C.
Warren, John M., 305 Prince George's Street, Laurel, Md.
§Watkins, Dayton O., 5208 Annapolis Road, Bladensburg, Md.
Weaver, Frank L., Jr., 320 Montgomery Street, Laurel, Md.
Weintraub, William C., 45 Q Ridge Road, Greenbelt, Md.
Weiss, Moe, Glen Dale Hospital, Glen Dale, Md.
Whelton, Richard L., 1021 University Boulevard, East Longley Park, Silver Spring, Md.
Wilkinson, Rowland F., 4404 Queensbury Road, Riverdale, Md.
Wingfield, Robert C., 311 Thomas Drive, Laurel, Md.
§Wodak, Hans, 30-C Ridge Road, Greenbelt, Md.
§Wolfe, Henry R., 905 Sheridan Street, Hyattsville, Md.

Queen Anne's County

Callison, Caroline H., Queen Anne County Health Department, Centreville, Md.
§Fisher, W. H., Centreville, Md.
Hoyt, Irvin G., Queenstown, Md.
Layton, C. Rodney, Centreville, Md.
McPherson, H. F., Centreville, Md.
Sattelmaier, Theodor, Stevensville, Md.

St. Mary's County

Barbarich, Michael, Laurence Avenue, Leonardtown, Md.
Bean, Philip J., Great Mills, Md.
Berube, Leon W., Mechanicsville, Md.
Boyd, William D., Leonardtown, Md.
Fuchs, Robert T., Leonardtown, Md.
Gill, Joseph E., Leonardtown, Md.
Greenwell, Charles, Leonardtown, Md.
Greenwell, Francis Floyd, Leonardtown, Md.
Guyther, J. Roy, Mechanicsville, Md.
Hall, Roberta Jean, % LCDE C. H. Stephens, N.A.S. Operations Dept., Patuxent River, Md.
Houser, Alan D., Leonardtown, Md.
Johnson, Leonard B., Morganza, Md.
Lane, Julian S., 317 Great Mills Road, Lexington Park, Md.
Mossman, David L., Mechanicsville, Md.
Patrick, William H., 323 Midway Drive, Lexington Park, Md.
Rehm, Ernest D., Route 1, Box 441 A, Lexington Park, Md.
Sothoron, L. J., Charlotte Hall, Md.

Somerset County

§Barr, A. N., Crisfield, Md.
§Collins, Clarence E., Crisfield, Md.
Coulbourn, George C., Marion Station, Md.
Coulbourn, William H., Crisfield, Md.
Johnson, Robert H., Princess Anne, Md.
Lewis, Archie C., Princess Anne, Md.
Peyton, Sarah M., Crisfield, Md.
Rawley, C. G., Crisfield, Md.

Talbot County

Ambler, J. Thompson B., 214 Dover Street, Easton, Md.
Baker, J. Tyler, Box 361, Easton, Md.
Bartley, Donald F., 9 N. Hanson Street, Easton, Md.
§Baybutt, John E., 205 Earle Avenue, Easton, Md.
Buell, Martin F., Easton, Md.
Bullwinkel, Henry G., 131 S. Harrison Street, Easton, Md.
Cecil, A. B., Jr., Easton, Md.
Cox, P. Evans, Easton, Md.
Eareckson, Vincent O., Jr., 300 South Hanson Street, Easton, Md.
Eglseder, Ludwig J., Easton, Md.
Garnett, James H. P., Easton, Md.
Green, John Summerfield, III, Easton Memorial Hospital, Easton, Md.
Hammond, W. T., Easton, Md.
§Harrison, Thurston, Easton, Md.
Kerr, H. Dabney, St. Michaels, Md.
Kinnamon, Howard F., Easton, Md.
Krech, Shepard, Jr., 9 N. Hanson Street, Easton, Md.
Lederer, Kurt, Queen Anne, Md.
Noble, William D., 2 S. Hanson Street, Easton, Md.
Palmer, Margaret V., Easton, Md.
Palmer, W. N., Easton, Md.
Perkins, R. L., Royal Oak, Md.
Reeser, Guy M., Tilghman's Island, Md.
Reeser, Guy M., Jr., St. Michaels, Md.
Robinson, John N., Easton, Md.
Schmidt, Edward C. H., Easton Hospital, Easton, Md.
Schneider, John F., Box 67, Easton, Md.
Seymour, William S., Trappe, Md.
Tarr, Norman, Easton, Md.
Welty, Louis S., Easton, Md.
Winters, William L., 210 East Dover Street, Easton, Md.
Wroth, R. Lane, St. Michaels, Md.

Washington County

§Bacon, A. Maynard, Jr., 302 N. Potomac Street, Hagerstown, Md.

§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

§Beachley, Jack H., 221 West Washington Street, Hagerstown, Md.
Beckner, William Walter, Jr., 251 E. Baltimore Street, Hagerstown, Md.
§Bell, Royal A., 119 N. Potomac Street, Hagerstown, Md.
§Binford, Richard T., 1135 Potomac Avenue, Hagerstown, Md.
§Binkley, O. H., 444 Summitt Avenue, Hagerstown, Md.
Blair, Harry Edwin, 214 N. Potomac Street, Hagerstown, Md.
§Bowman, Harry Daniel, 318 N. Potomac Street, Hagerstown, Md.
§Boyer, David J., Jr., 135 N. Potomac Street, Hagerstown, Md.
§Brewer, David R., Clear Spring, Md.
§Brumback, Frank Edgar, 170 W. Washington Street, Hagerstown, Md.
*Brumback, Lynn H., 170 W. Washington Street, Hagerstown, Md.
§Cameron, W. Ross, 909 Rolling Road, Hagerstown, Md.
§Campbell, Edgar Thrall, 145 W. Washington Street, Hagerstown, Md.
§Campbell, Robert Van Lieu, 145 West Washington Street, Hagerstown, Md.
§Campbell, William D., Hagerstown, Md.
§Cohen, Archie Robert, Clear Spring, Md.
§Conrad, Robert P., 137 W. Washington Street, Hagerstown, Md.
§Crisp, Joseph Calvin, 115 King Street, Hagerstown, Md.
§Ditto, E. W., Jr., 1702 Cathedral Street, Hagerstown, Md.
§Ditto, Edward W., III, 217 W. Washington Street, Hagerstown, Md.
§Dobbie, John James, 115 King Street, Hagerstown, Md.
Donnellan, Elaine Kidwell, 131 W. Washington Street, Hagerstown, Md.
§Dove, Frederick Denton, Jr., 214 N. Potomac Street, Hagerstown, Md.
§Dwyer, James Richard, 245 N. Potomac Street, Hagerstown, Md.
§Funch, Hans Christian, Fairchild Aircraft Corporation, Showalter Road, Hagerstown, Md.
§Gilmer, H. D., 32 McKee Avenue, Hagerstown, Md.
§Gist, Harold H., 111 N. Potomac Street, Hagerstown, Md.
§Graff, Frederick L., 116 W. Washington Street, Hagerstown, Md.
§Graff, Henry F., 116 West Washington Street, Hagerstown, Md.
§Graff, Louis George, 119 E. Antietam Street, Hagerstown, Md.
§Greene, D. Crosby, 1302 Pennsylvania Avenue, Hagerstown, Md.
§Haak, Paul, 28 W. Potomac Street, Williamsport, Md.
§Harrison, Paul, 318 N. Potomac Street, Hagerstown, Md.
§Hauver, Richard V., 138 W. Washington Street, Hagerstown, Md.
Hess, Charles Franklin, Smithsburg, Md.
§Hirshman, P. J., 159 W. Washington Street, Hagerstown, Md.
§Hoachlander, Eldon George, 115 W. Washington Street, Hagerstown, Md.
§Hoffman, Lloyd A., 214 N. Potomac Street, Hagerstown, Md.
§Hornbaker, John H., 158 W. Washington Street, Hagerstown, Md.
§Houghton, Ira Luther, 26 Laurel Street, Hagerstown, Md.
§Jennings, George, 136 W. Washington Street, Hagerstown, Md.
§Keadle, Robert F., 318 N. Potomac Street, Hagerstown, Md.
§Kehne, John Herr, 131 W. Washington Street, Hagerstown, Md.
§Kneisley, Bender B., 148 W. Washington Street, Hagerstown, Md.
Kohler, G. A., Smithsburg, Md.
§Layman, J. Walter, 100 Professional Arts Building, Hagerstown, Md.
§Layman, William T., 100 Professional Arts Building, Hagerstown Md.
§Le Van, Gerald W., Box 278, Boonsboro, Md.
§Link, Vaughen H., 245 North Potomac Street, Hagerstown, Md.
§Lusby, Frank F., 230 N. Potomac Street, Hagerstown, Md.
§Lyon, Isadore B., Western Maryland State Hospital, Hagerstown, Md.
§Macht, Stanley Howard, Washington County Hospital, Hagerstown, Md.
§Moran, John A., 215 W. Washington Street, Hagerstown, Md.
§Mowrer, C. L., 159 W. Washington Street, Hagerstown, Md.
§Novenstein, Sidney, Funkstown, Md.
§Packer, Lawrence Leroy, Jr., 145 W. Washington Street, Hagerstown, Md.
§Poole, Ernest F., 138 W. Washington Street, Hagerstown, Md.
Ramsey, James H., 806 Rolling Road, Hagerstown, Md.
§Sacchet, Hugo Anthony, 251 E. Baltimore Street, Hagerstown, Md.
§Sachs, James Wilbur, 251 E. Baltimore Street, Hagerstown, Md.
§Shaffer, Lester M., Hancock, Md.
§Shealy, Walter H., Sharpsburg, Md.
Shupp, F. F., 109½ North Potomac Street, Hagerstown, Md.
§Smoot, Merrill C., 703 Oak Hill Avenue, Hagerstown, Md.
Spence, James E. H., Western Maryland Railway, Hagerstown, Md.
§Sprecher, Omar Daniel, Jr., 314 N. Potomac Street, Hagerstown, Md.
§Stauffer, R. S., 170 W. Washington Street, Hagerstown, Md.
Sullivan, E. Margaret, 314 N. Potomac Street, Hagerstown, Md.
Tabler, Homer, Hancock, Md.
§Tobias, Herbert R., Berkeley Springs, West Virginia
§Turner, James E., Dept. Radiology, Washington County Hospital, Hagerstown, Md.
§Turner, Roy Byron, 668 Orchard Road, Hagerstown, Md.
§Waddill, Samuel Frear, 115 King Street, Hagerstown, Md.
§Warden, Jacob Garvin, 832 Potomac Avenue, Hagerstown, Md.
§Weeks, Howard N., 136 N. Potomac Street, Hagerstown, Md.
§Wells, Samuel Robert, 115 N. Potomac Street, Hagerstown, Md.
§Welty, Dalton M., E. Hillcrest at Potomac Street, Hagerstown, Md.
§Wilson, John Dean, 1049 Woodlawn Way, Hagerstown, Md.
§Young, Ralph F., 101 E. Potomac Street, Williamsport, Md.
§Young, Richard Atlee, 302 N. Potomac Street, Hagerstown, Md.
§Young, S. Earl, 148 N. Potomac Street, Hagerstown, Md.

* Deceased.
§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

Worcester County

Cohen, Paul, Snow Hill, Md.
Grubb, Robert A., 5 Bay Street, Berlin, Md.
La Mar, Robert C., Snow Hill, Md.
O'Donnell, T. F., 1507 Dean Drive, Waycross, Ga.
Robbins, Herman A., 5 Bay Street, Berlin, Md.
‡Sartorius, Norman E., Pocomoke City, Md.
Sartorius, Norman E., Jr., Pocomoke City, Md.
‡Schott, Clifford E., 310 N. Main Street, Berlin, Md.
Thomas, Nathanael R., Philadelphia Ave. at 9th Street, Ocean City, Md.
Townsend, Francis J., Jr., Somerset Street, Ocean City, Md.
Trader, Charles W., 302 Market Street, Pocomoke City, Md.
Waesche, Fred S., Snow Hill, Md.

Wicomico County

Baker, Robert L., Medical Center, S. Salisbury Boulevard, Salisbury, Md.
Beardsley, Earl M., Maryland Avenue, Salisbury, Md.
Bishop, James R., E. Main Street, Salisbury, Md.
Bloxom, John M., III, Medical Center, Salisbury, Md.
§Briele, Henry A., Medical Center, Salisbury, Md.
Burton, Oswald J., 211 Maryland Avenue, Salisbury, Md.
Cayaves, Paul G., 222 N. Division Street, Salisbury, Md.
Christensen, Osborne D., 321 S. Division Street, Salisbury, Md.
Cooper, H. Douglas, Medical Center, Salisbury, Md.
§Dumeyer, William, Peninsula General Hospital, Salisbury, Md.
Eccleston, H. M., Jr., Peninsula General Hospital, Salisbury, Md.
Ellis, Wilber R., Jr., Medical Center, Salisbury, Md.
§Emrich, William, Hebron, Md.
Fisher, William Henry, Jr., Medical Center, Salisbury, Md.
Gallaher, James Patrick, Medical Center, Salisbury, Md.
Gardner, Rufus S., Jr., 321 S. Division Street, Salisbury, Md.
§Gillis, Marion Howard, Jr., 206 Walnut Street, Salisbury, Md.
§Gilmore, David J., Medical Center, Salisbury, Md.
Gore, Robert J., Deers Head Hospital, Salisbury, Md.
Gramse, Fred R., 402 S. Division Street, Salisbury, Md.
§Gray, William David, 334 Camden Avenue, Salisbury, Md.
Hanson, I. Rivers, Medical Center, S. Salisbury Boulevard, Salisbury, Md.
Hearn, Carrie I., 226 N. Division Street, Salisbury, Md.
Hill, Thomas C., 224 N. Division Street, Salisbury, Md.
Howard, William L., 222 N. Division Street, Salisbury, Md.
Hurdle, Seth H., Wicomico County Health Department, Watson Memorial Building, Salisbury, Md.
Insley, Philip A., East Main Street, Salisbury, Md.
Kolls, Alfred C., 411 W. College Avenue, Salisbury, Md.
Kuhlman, Harry S., Sharptown, Md.
Lawrence, Margaret, 226 A W. Main Street, Salisbury, Md.
Lawry, Lee L., Jr., Fruitland, Md.
Ledermann, Alfred S., Medical Center, Salisbury, Md.
§Lewis, Frank R., Willards, Md.
Linberg, Eugene, Medical Center, Salisbury, Md.
§Long, William B., Medical Center, Salisbury, Md.
McCullough, Kendrick, Peninsula General Hospital, Salisbury, Md.
§Mann, Hunter R., Jr., Maryland Avenue, Salisbury, Md.
Mattax, Alberta Malcarney, 711 Camden Avenue, Salisbury, Md.
Mattax, Harry McCoy, 711 Camden Avenue, Salisbury, Md.
§Mitchell, Andrew C., 211 Maryland Avenue, Salisbury, Md.
Morgan, W. C., Medical Center, Salisbury, Md.
Newman, A. Carleton, 704 Camden Avenue, Salisbury, Md.
§Poole, Frank E., 111 Davis Street, Salisbury, Md.
Purnell, E. A., 652 West Main Street, Salisbury, Md.
Ritchings, E. Peyton, Pine Bluff State Hospital, Salisbury, Md.
§Royer, Earl Linwood, 407 Camden Avenue, Salisbury, Md.
Saunders, Richard H., Nanticoke, Md.
Saunderson, Robert W., Jr., 926 N. Division Street, Salisbury, Md.
Sembly, G. Herbert, 400 E. Church Street, Salisbury, Md.
Smith, Stedman W., 706 Camden Avenue, Salisbury, Md.
Smith, Theodore S., Peninsula General Hospital, Salisbury, Md.
§Smith, William B., Medical Center, Salisbury, Md.
§Sohler, L. V., 303 East Street, Delmar, Md.
Sutter, Everett, Dames Quarters, Md.
Tamasi, Joseph J., 911 Camden Avenue, Salisbury, Md.
Thompson, Ollie H., 204 N. Division Street, Salisbury, Md.
Wanner, Jesse R., Jr., 228 N. Division Street, Salisbury, Md.
Waters, Zack J., Medical Center, Salisbury, Md.
Womack, William S., 706 Camden Avenue, Salisbury, Md.
§Yow, Raymond, 707 Camden Avenue, Salisbury, Md.

Non-Resident Members

Archibald, Reginald M., Hospital of the Rockefeller Institute for Medical Research, 66th Street and York Avenue, New York 21, New York
Austrian, Robert, Kings County Hospital, F. Building, Brooklyn 3, N. Y.
Bachman, Leonard, 325 Highland Lane, Bryn Mawr, Pa.
Bacon, Robert B., Cedar Crest, R. 2, Box 716, Fairfax, Va.
Ballina, Jones B., 800 N.E. 13th Street, Oklahoma City, Okla.
Barrow, Bernard, Blackstone, Va.
Belger, William T., Jr., Ministerial Branch, R.F.D.-2, Manchester, N. H.
Blain, Donald G., 841 Balfour Road, Grosse Pointe Park 30, Mich.
Blair, Emil, Fitzsimons General Hospital, Denver, Colo.
Brackin, John T., Jr., Abington Memorial Hospital, Abington, Pa.

‡ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

Braun, Manfred, % V. A. Hospital, 130 W. Kingsbridge Road, Bronx 68, N. Y.

Brimmer, Karl W., 1550 Miller Road, Coral Gables, Fla.

Bronos, George J., 310 Maple Street, Holyoke, Mass.

Brown, Lida Crockett, Northern State Hospital, Sedro-Woolley, Wash.

Brown, Merrill W., 5208 Constitution, N.E., Albuquerque, N. Mex.

Bryan, Elizabeth Lynn, 146 Columbia Heights, Brooklyn 2, New York

Byerly, William L., Jr., 905 Carolina Avenue, Hartsville, S. C.

Carroll, Charles F., Jr., 115 Ball Street, Beckley, W. Va.

Cavanagh, Denis, Department of Obstetrics-Gynecology, Jackson Memorial Hospital, Miami 38, Fla.

Cobb, John Candler, Box 124 A, South Sta Rte., Sandoval, New Mex.

Cook, Sarah, 3103-10th Street, North, Arlington 1, Va.

Cope, Freeman W., 54 E. Moreland Avenue, Hatboro, Pa.

Copeland, Murray M., The Westchester, Apt. 208-B, 4000 Cathedral Street, N.W., Washington 16, D. C.

Dana, George W., Dir, North Shore Hospital, Manhasset, L. I., N. Y.

Davis, Bernard M., Jr., 117 North Claudina Street, Anaheim, Calif.

Devlin, Andrew Joseph, Jr., St. Luke's Hospital, Spokane 11, Wash.

Dickey, Francis G., 2898 Rockingham Drive, N.W., Atlanta 5, Ga.

Elder, John D., Jr., Dept. of Anest., State Univ. of N.Y. College of Medicine, 451 Clarkson Ave., Brooklyn, N. Y.

Erickson, Robert L., Rosemount, Minn.

Farmer, William L., Jr., 8633 John Road, Detroit 2, Mich.

Fleck, Warren L., 1112-59th Street, Downers Grove, Ill.

Futterman, Perry, Beckley Memorial Hospital, Beckley, W. Va.

Geiling, E. M. K., Dept. Pharmacology, University of Chicago, Chicago, Ill.

§Gerwig, Walter H., Jr., 1805 Kenyon Street, N.W., Washington, D. C.

Godlove, John Carlton, 102 S. Maple Avenue, Martinsburg, W. Va.

Goldenthal, Sumner, 955 Ridge Road, Hamden 17, Conn.

Greco, William R., 1328½ Newcastle Street, Brunswick, Ga.

*Graham, Robert Lee, Winter Veterans Administration Hospital, Topeka, Kans.

Greif, Roger Louis, Cornell University Medical Center, 1300 York Avenue, New York 21, N. Y.

Griffith, Paul Condon, 7302-9th Avenue, N.W., Seattle, Wash.

Gurney, Charles B., 115 E. Arrowood Road, Oakridge, Tenn.

Hauber, Frank D., Currey Clinic, 205–07 Spears Avenue, Chattanooga, Tenn.

Heinbach, Wilfred F. & Anne B., Department of Pathology, Memorial Hospital of Chester County, West Chester, Pa.

Heinlein, Christian Paul, 504 Forest Avenue, Greensboro, N. C.

Heisse, John W., Jr., 224 Crescent Road, Burlington, Vt.

Hoffmeister, Ferdinand S., Department of Reconstructive Surgery, Roswell Park Memorial Institute, Buffalo 3, N. Y.

Houman, Carl, Empress Zauditu Memorial Hospital, P.O. Box 316, Addis Ababa, Ethiopia

Jenkins, Rose D., 1720 So. Hobart Boulevard, Los Angeles, Cal.

Johnson, Warren C., 1785 Massachusetts Avenue, N.W., Washington, D. C.

Jones, Thomas L., Research Associate, Wm. S. Merrell Co., Cincinnati 15, Ohio

Keeney, Edmund L., 476 Prospect Street, La Jolla, Calif.

Kupfer, Carl, 15 Trowbridge Street, Cambridge, Mass.

Langeluttig, H. Vernon, Missouri State Sanitorium, Mt. Vernon, Mo.

Lipin, Raymond J., V.A. Hospital, 300 E. Roosevelt Road, Little Rock, Ark.

Lukens, David, 415 W. 2nd Street, Hutchinson, Kans.

Lyford, John, III, Veterans Administration Hospital, Louisville 2, Ky.

Lyon, William C., 2530 Beechwood Circle, Ft. Wayne, Ind.

McGeehan, James S., 1000 Oliver, Owosso, Mich.

McGrady, Charles W., 2701 Atlantic Boulevard, Pompano Beach, Fla.

McGrady, Kathleen R., 3025 W. Broward Boulevard, Ft. Lauderdale, Fla.

McKewen, Jane B., 705-18th Street, N.W., Washington 6, D. C.

Miller, Robert T., Mountain Lake, Lake Wales, Fla.

Mitchell, William Arthur, 201 Hemenway Building, Lufkin, Texas

Molofsky, Leonard Carl, Kaiser Foundation Hospital, Broadway & McArthur Boulevard, Oakland 11, Calif.

Neff, C. A., 31 Leggett Drive, Porterville, Calif.

Park, William F., U.S.S. Antietam, CVS-36, F.P.O., New York

Peirce, E. Converse, II, 4107 Tazewell Pike, Knoxville 18, Tenn.

Piper, Donald E., 117 W. Main Street, Dallastown, Pa.

Pratt, Daniel Wells, MC, 0409089, 130th Station Hospital, APO 403, New York, N. Y.

Raskin, Howard Frank, University of Chicago, Department of Medicine, Chicago 37, Ill.

Risley, John P., 2305 Jackson Street, Waukegan, Ill.

Schenthal, Joseph Edwin, 1328 Aline Street, New Orleans 15, La.

Scherr, Merle S., 803 Atlas Building, Charleston 1, W. Va.

Schubart, Adalbert F., Massachusetts General Hospital, Boston, Mass.

Seaton, Ronald S., St. Luke's Hospital, Vengurla, Ratnagiri Dist. B.S., India

Shelley, Harry S., 3725 Estes Avenue, Nashville, Tenn.

Shub, Maurice I., 559 Hillside Avenue, Elmhurst, Ill.

* Deceased.

§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

Simpson, Marshall A., P.O. Box 1414, Palmer, Alaska
Slager, Ursula T., Los Alamos Medical Center, Los Alamos, N. Mex.
Smith, George W., Medical College of Georgia, Augusta, Ga.
Smith, Willard F., 1409 Van Buren Street, Wilmington, Del.
Steinberg, Stanley H., 5223 South Dakota Avenue, N.E., Washington 11, D. C.
§Stevens, Walton E., 1705 Essex Road, Rutledge, Charlottesville, Va.
Thompson, Charles B., The Lifwynn Foundation, 52 S. Morningside Drive, Westport, Conn.
Virgilio, Frank D., Comsubnelm/Combedsuppact, Navy 510, % F.P.O., New York
Welsh, W. W., Gabbs, Nevada
Werbner, Izydor, 554 West Indianola Avenue, Youngstown 11, Ohio
White, Joseph M., Blackberry Lane, Morristown, N. J.
White, Mary Louise T., Blackberry Lane, Morristown, N. J.
Wolf, Frederick S., Hdq. Air University Command, Maxwell Air Force Base, Montgomery, Ala.
Wu, Jackson S., % Pathology Dept., City of Hope Medical Center, Duarte, Calif.
Young, Leroy J., 5414 S. Compton Avenue, Los Angeles 11, Calif.

§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

WIDOWS OF FORMER MEMBERS OF THE MEDICAL AND CHIRURGICAL FACULTY WHO ARE MEMBERS OF THE WOMAN'S AUXILIARY

Austrian, Mrs. Charles R., 1417 Eutaw Place, Baltimore 17, Md.
Balfour, Mrs. Charles E., 103 Elmwood Rd., Baltimore 10, Md.
Ball, Mrs. Peter, 1834 Glen Ridge Rd., Baltimore 4, Md.
Barker, Mrs. Lewellys F., 208 Stratford Road, Baltimore 18, Md.
Bauersfeld, Mrs. Emil G., 3916 Virgilia Street, Chevy Chase 15, Md.
Bender, Mrs. William, 1140 Potomac Ave., Hagerstown, Md.
Briele, Mrs. Myrtle G., 1506 Harford Rd., Baltimore 14, Md.
Constadt, Mrs. Hans W., 500 Stoneleigh Road, Baltimore 12, Md.
Dandy, Mrs. Walter E., 3904 Juniper Road, Baltimore 18, Md.
Fairchild, Mrs. S. R., 118 E. Magnolia Street, Hagerstown, Washington Co., Md.
Foley, Mrs. Charles J., 400 S. Union Ave., Havre de Grace, Md.
Gardner, Mrs. S. H., 56 Broadway, Hagerstown, Md.
Hoffmeier, Mrs. Frank N., 442 N. Potomac Ave., Hagerstown, Washington Co., Md.
Holly, Mrs. Julius D., 7701 Seven Mile Lane, Baltimore 8, Md.
Howe, Mrs. Julian, Box 195, Olney, Md.
Jerardi, Mrs. Joseph V., 107 Armagh Drive, Baltimore 12 Md.
Kloman, Mrs. Erasmus H., 600 Edgevale Rd., Baltimore 2, Md.
Lloyd, Mrs. Oliver S., 5402 Purlington Way, Baltimore 2, Md.
Lubin, Mrs. Paul, 3819 Chatham Road, Baltimore 18, Md.
Miller, Miss Isabelle (Daughter), 218 Mealy Parkway, Hagerstown, Washington Co., Md.
Miller, Mrs. Warren D., 218 Mealy Parkway, Hagerstown, Washington Co., Md.
Mortimer, Mrs. Egbert L., Jr., 207 Paddington Road, Baltimore 12, Md.
Nock, Mrs. Randolph M., 114 E. William St., Salisbury, Wicomico Co., Md.
Norment, Mrs. Richard B., Conococheague, Washington Co., Md.
Sinton, Mrs. William A., 1500 Ralworth Road, Baltimore 18, Md.
Stewart, Mrs. George A., 5300 St. Albans Way, Baltimore 12, Md.
Ward, Mrs. Grant E., 602 W. University Parkway, Baltimore 10, Md.
Wroth, Mrs. Peregrine, Jr., 145 W. Prospect St., Hagerstown, Md.
York, Mrs. J. Arthur, 806 Belvedere Ave., Baltimore 10, Md.

Letters Of Interest

June 2, 1958

Dr. George H. Yeager, Editor
Maryland State Medical Journal
1211 Cathedral Street
Baltimore 1, Maryland

Dear Dr. Yeager:

The enclosed announcement is being mailed to a list of approximately 3,000 physicians who have indicated special interest in being informed of the kinds of patients we may be interested in admitting for study purposes. We would appreciate you giving consideration to this announcement for possible publication in your journal.

Sincerely,
Judson Hardy
Information Officer
The Clinical Center

June, 1958

To: Special List of Interested Physicians

For physicians who may be interested in referring certain patients for study at the Clinical Center of the National Institutes of Health, Bethesda, Maryland, the following information is provided concerning diagnoses that are of particular current interest. This list supplements a more extensive compilation published each year in booklet form.

Letters of referral should include an adequate history and may be addressed to the Director of the Clinical Center for registration and circulation among appropriate clinical groups. A full report of findings will be furnished the referring physician when an accepted patient is discharged back to his care.

The National Cancer Institute has particular interest in patients with the following diagnoses: Acute leukemia, any age; Hodgkins disease without previous therapy; multiple basal cell cancers of the skin; myeloid metaplasia; protein disturbances such as macroglobulinemia, cryoglobulinemia, and idiopathic hypoalbuminemia; cancer of any type in children; choriocarcinoma.

As candidates for radiological study and treatment patients in the following categories will be considered: Invasive carcinoma of the urinary bladder without bony or extra-pelvic metastases and without previous external radiation therapy or extra-vesical surgery; squamous cell carcinoma of the oropharyngeal and laryngeal cavities; carcinoma of the esophagus without evidence of metastases to neck or liver; carcinoma of thyroid; solitary myeloma; chondrosarcoma.

The Allergy and Infectious Diseases Institute has especial current interest in proven or strongly suspected cases of disseminated histoplasmosis. Studies include improved diagnostic methods, new therapeutic agents and basic immunology.

The National Heart Institute has particular need for patients with hormone producing malignancies of the adrenal gland for trial of Δ^4 cholestenone, which is an inhibitor of adrenal steroid synthesis. Patients with post-operative recurrences of adrenal malignancy are also considered suitable for trial.

Other conditions of interest to Heart Institute investigators include: Malignant hypertension, primary pulmonary hypertension, and cases which though sustained have had no serious cardiac, renal or cerebral complications; angina pectoris clearly associated with coronary artery disease; pheochromocytomes; adrenogenital syndrome.

To: President and Executive Secretary, State Medical Association
President and Executive Secretary, State Hospital Association
President and Executive Secretary, State Public Health Association
From: Dr. Rozella Schlotfeldt, Chairman, NLN Fellowship Program, Committee on Awards
Re: NLN Fellowship Program

Date: June 12, 1958

Your knowledge of the total health needs of the nation as well as your close affiliation with the nursing profession have undoubtedly made you acutely aware of the continuing and growing demand for nurses who are prepared to accept leadership positions in nursing administration and nursing education and to engage in research in the field of nursing. There is urgent need to have a diligent and constant search for nurses with outstanding ability and leadership potential and to provide opportunities for such persons to have advanced education.

The purpose of the NLN Fellowship Program is to find nurses with these qualifications and to provide funds to subsidize their programs of graduate study. This program, made possible by a grant from the Commonwealth Fund, has been in existence for four years and during this time seventy-two grants for doctoral study and twenty-four grants for master's study have been awarded. We are eager to find fellowship applicants for study beginning September, 1959 who will make significant contributions to nursing after a period of advanced study.

We are seeking your assistance in publicizing this opportunity for nurses and shall deeply appreciate your inclusion of this *information in your state bulletin inasmuch as personnel in allied disciplines have an excellent opportunity to know nurses who* have demonstrated superior abilities and leadership qualities.

Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

MEDICAL CARE PROGRAM IN ALLEGANY COUNTY

Dr. Page Jett of Prince Frederick, Maryland, addressed the Allegany-Garrett County Medical Society on the subject of the Medical Care program as related to the State health program in Allegany and Garrett Counties. Dr. Jett presented some startling figures relative to the costs of "Medical Care" in Allegany County. His figures showed that the cost of operation of this program in Allegany County was the highest in the State, both in total cost and in charges for druggists' prescriptions.

Dr. Hilda Walters, President, Allegany-Garrett County Medical Society; Dr. Alice Tobler, State Department of Health; Dr. Page Jett, Prince George's County, Speaker; and Dr. Carlton Brinsfield, Secretary, Allegany-Garrett County Medical Society.

Dr. Alice Tobler also presented facts and figures and stated that it was to the interest of everybody concerned for "Medical Care" costs to be kept to a minimum in order that it would not be necessary to prorate payments in the future. The quality of the work was not criticized but it was felt that the cost of "Medical Care" should be lowered, if possible.

The cost of the "Medical Care" program in Allegany County has always been among the highest in the State, and was increasingly high this Spring. The monthly average was from $10,000 to $11,000 during the past year.

Two groups are eligible for free medical and dental services. The first consists of those on the county relief rolls. As such they are automatically eligible for free medical service. The second group is made up of the medically indigent. This group is composed of individuals who cannot pay their medical expenses but who are otherwise self-supporting.

It was noted that physicians and dentists who treat "Medical Care" patients do so at reduced rates. Minimum markups are allowed for medicines dispensed by pharmacists.

To pay the costs of the "Medical Care" program, fifty cents is collected from each citizen of Maryland. Two out of every one hundred persons in Maryland received free medical care under this program.

X-RAY RADIATION HAZARDS

At a recent inspection by the State Health Department, the x-ray facilities of the Allegany County Health Department were criticized and measures were taken to modernize the equipment. It was felt there was too much scattered radiation from the x-ray machine.

This survey emphasizes the importance of proper equipment and trained personnel in any situation where people's health is concerned. Should x-ray pictures be taken by lay personnel, when not under the direct and immediate supervision of physicians? Should all x-rays be taken as a part of the Blue Shield plan, under contract by the participating parties and should an accurate record of all radiation received by each person be kept? Should all x-rays be taken in physicians' offices, or in hospitals?

These are questions that should be asked and settled. Medical group organizations should take the lead now, for the protection of the public.

MEDICAL GROUP STUDIES SAFETY IN SPORTS CAR RACES

The American Association for Automotive Medicine was organized in Cumberland, Maryland early

in 1958. The purposes of this association are to provide more safety measures for the driving of sports cars in competitive races.

The association was organized by seven physicians, members of the National Medical Advisory Committee formed by the Sports Car Club of America. This association will provide medical advice on health and safety measures in all motor car competition. There are approximately one hundred members throughout the United States.

Dr. Abraham J. Mirkin is the newly elected president.

DR. FAW ELECTED TO BANK BOARD

The Board of Directors of the First National Bank of Cumberland, at a recent meeting, elected to its membership Dr. Wylie M. Faw, Jr., of 531 Washington Street, Cumberland.

Dr. Faw is a graduate of Allegany High School, Randolph Macon College and the University of Maryland Medical School. He served in World War II as colonel in command of a hospital ship. Later he was Chief of Surgery in Gorgas Hospital, Panama. Dr. and Mrs. Faw have two children.

PERSONALS

Top honor graduates of Allegany High School, in 1958, were children of Cumberland physicians, Dr. and Mrs. Leland Ransom, Dr. and Mrs. Lewis Brings, and Dr. and Mrs. W. Royce Hodges, are the proud parents.

Joel Jay Jacobson, son of Dr. and Mrs. Samuel M. Jacobson, Cumberland (recently a graduate of Dickinson College) Carlisle, Pennsylvania, will enter the University of Maryland Medical School this Fall.

A. Leo Franklin, grandson of the late Dr. A. Leo Franklin, has just graduated with a Bachelor's Degree in Science from the University of Maryland and will enter the University of Maryland Medical School in September. Mr. Franklin's grandfather, who was a surgeon for many years in Cumberland, graduated from the University of Maryland in 1902 and served his residency in the University Hospital. He died in 1934.

BALTIMORE COUNTY MEDICAL ASSOCIATION

CHARLES HERMAN WILLIAMS, M.D.
Journal Representative

MINUTES OF MAY 19, 1958 MEETING

The regular meeting of the Baltimore County Medical Association, Inc., was held at 1:00 P.M., Wednesday, May 19, 1958, University Hospital, President Clarence E. McWilliams, presiding.

Following luncheon the minutes of the meeting held April 23, 1958 were approved with the exception of substituting the word "opinion" for "suggestion" in the third paragraph on page 1.

Dr. McWilliams advised that Dr. Bartemeier was interested in having informal meetings at Seton Institute with a group of about 20 to 30 doctors at a time, to discuss problems which physicians may have in general practice. Dr. McWilliams said he will issue the information and give the doctors an opportunity to set the time they would like to attend.

Dr. Warthen advised that the Survey of the Health Department which Dr. Stebbins discussed at a previous meeting had been completed and will be studied in great detail at weekly meetings of the County Council. A summary and recommendation had been prepared and will be distributed to the members of the Association.

Dr. Reese advised that the meeting in June would be held at the Stafford Hotel on June 18 at which time the Auxiliary would present the Annual Nursing Scholarship. Also at the meeting a film entitled "Time and Two Women" from the Maryland Cancer Society will be shown. In July there will not be a meeting and the doctors were urged to attend the Annual Crab Feast at Duffy's in August. Dr. Reese then introduced Dr. John Dennis who presented the speaker, Dr. Fernando Bloedorn, Associate Professor of Radiology, University of Md. School of Medicine.

Dr. McWilliams thanked Dr. Stone and Dr. Bloedorn for the hospitality extended the members.

There being no further business to discuss the meeting adjourned.

FREDERICK COUNTY MEDICAL SOCIETY

LOUIS R. SCHOOLMAN, M.D.

Journal Representative

The May meeting of the Society was held at the Francis Scott Key Hotel on the 20th. The guest speaker was Dr. George P. Blundell, chief of the Pathology Division, Fort Detrick. He gave a most enlightening talk on "Fluorescent Antibody Techniques as Applied to Identification of Bacteria in Formaldehyde-Fixed Tissue."

During the business session which followed, there was a spirited discussion of the State-wide poll on Social Security. The result was a resolution sent to the President of the Medical and Chirurgical Faculty, protesting the inclusion of propaganda with the poll card.

HARFORD COUNTY MEDICAL SOCIETY

FREDERICK J. HATEM, M.D.

Journal Representative

The Harford County Medical Society meetings have continued this year with increasing interest and attendance. The two main reasons for this have been the delicious meals served at our monthly dinner meetings held at the Bayou Restaurant in Havre de Grace and the excellent speakers obtained by our program chairman, Dr. James McC. Finney.

Dr. James Miller spoke at our February meeting on a relatively new theory of the cause and treatment of low back pain. In March, Dr. Lawrence Finberg, pediatrician, spoke on electrolyte balance. In April, Dr. Milton Sachs gave an excellent outline of the blood clotting mechanism and the hemorrhagic disorders. Our guest speaker in May was Dr. Edward Stafford, who brought us up to date on the prevention and treatment of tetanus.

HOSPITAL NEWS

The addition to the southeast wing and the third floor north wing of our hospital have been completed and are in use. We are looking forward to the completion of the other additions and the renovation of the maternity section and new pediatric section.

PERSONALS

Dr. Frank Hauber is now associated with Drs. Ross Pierpont and William Brendle in the practice of general surgery in Havre de Grace.

Dr. Neil Gordon, who was the Deputy Health Officer for Harford County, has accepted an appointment and promotion out of the State.

The county medical society has recommended Dr. Dudley Phillips as an interim health officer until another is appointed by the State Department of Health.

Join the fun —

in the Sun

AT OCEAN CITY

FRIDAY, SEPTEMBER 12

OCEAN CITY

. . . The scene of the Semi-Annual Meeting Friday, September 12

Obituaries

Herbert Van Vechten Deming, M.D.

1880–1958

Dr. Herbert Van Vechten Deming, of Cumberland, died at the age of seventy-eight after a prolonged illness.

He was a graduate of the Atlantic Medical College, Baltimore, in 1907. Afterwards he interned for one year at St. Luke's Hospital, New York. He located in Cumberland in 1908.

He was an Emeritus member of the Allegany-Garrett County Medical Society, and for many years had served as its Secretary. He was also a member of the Medical and Chirurgical Faculty and of the American Medical Association.

He was the first physician-coroner in Allegany County, being appointed in 1939. In 1946 he became Deputy State Medical Examiner for Allegany County and held that position at the time of his death. Dr. Deming was an Elk and a Mason. He was married twice; his second wife and foster daughter survive him.

Lloyd W. Ketron, M.D.

1885–1958

Dr. Lloyd Ketron died on June 7th at the age of seventy-three. Dr. Ketron was a native of Tennessee, received his M.D. degree from Johns Hopkins University in 1911 and then went to Germany and Austria for graduate study.

He returned to Johns Hopkins University, School of Medicine, as Associate Professor of Dermatology. In 1928, he became Director of the Department of Dermatology of the Johns Hopkins Hospital and soon afterwards founded the Laboratory of Dermatohistopathology, where he continued to work even after his retirement from active practice in 1956.

Dr. Ketron is survived by his wife, two daughters and five grandchildren.

Edward I. Lederman, M.D.

1914–1958

Dr. Edward Isadore Lederman died on June 7th, at the age of forty-four. He will be remembered especially as a recent contributor to the Journal, having collaborated with two of his colleagues on a most interesting article "Hypnosis, an Adjunct to Anesthesiology."

He is survived by his widow, Mrs. Roberta Lederman, and by three children and two brothers.

Gertrud Sonnenfeldt, M.D.

1896–1958

Dr. Gertrud Sonnenfeldt, who passed away on June 2nd at the age of sixty-two, did not long survive her husband, Dr. Walther S. Sonnenfeldt, who died in February of this year. Dr. Sonnenfeldt was educated in Germany and conducted a medical practice there with her husband before coming to the United States in 1939.

Her attainments were many and varied. She specialized in obstetrics and in the rehabilitation of the physically and mentally handicapped. Later, she was for eight years psychiatrist in charge of the woman's group at Springfield State Hospital, where she died. Dr. Sonnenfeldt's survivors include two sons and four grandchildren.

"Death is the port where all may refuge find,

The end of labor, entry into rest."

William Alexander,
EARL OF STIRLING

Maryland
SOCIETY OF PATHOLOGISTS INC.
PAUL F. GUERIN, M.D., *President* ROBERT D. SOLOMON, M.D., *Secretary*
Sinai Hospital, Baltimore 5, Md.

SURGERY, SURGICAL PATHOLOGY AND DIAGNOSIS

Modern scientific medicine has available so many varied technical procedures that no one physician can hope personally to use all of them in his daily practice. Their optimal use, therefore, requires teamwork between clinician and pathologist. The examination of tissue removed at surgery illustrates this well.

Histopathologic examination of the specimen may determine at once whether the lesion is of neoplastic or inflammatory nature. If it is tumor the problem is frequently considered solved at this stage of examination but if inflammatory the treatment of the patient requires further study to determine the *cause* of the condition. It is no longer adequate to make a diagnosis of *caseous granuloma*, *non-caseous granuloma* or acute or chronic abscess. There are many common causes of caseous granuloma e.g., *Histoplasma capsulatum*, *Coccidioides immitis*, *Brucella abortus*, *Pasteurella tularense*, the virus of lymphogranuloma venereum, the agent of cat scratch fever and various types of acid fast bacilli, including of course the most common—the tubercle bacillus.

Special stains may be valuable to detect certain types of microorganisms but they seldom determine their identity. Thus *H. capsulatum* may be confused with *Leishmania donovani* or *Cryptococcus neoformans* or even the blastomycetes. The latter may also be confused with *C. immitis* because of the variability in the size of the spherules. The saprophytic or atypical acid fast bacilli, if found by special stains, are morphologically identical with *Mycobacterium tuberculosis*, *Mycobacterium balnei* or *Mycobacterium ulcerans*. Frequently, no organism may be found by any type of special staining so that no clue is available concerning even the general nature of the infection. In all these cases identification of the responsible member of a wide variety of agents capable of causing a given lesion depends on culture of that organism.

There are two essential considerations to be observed if satisfactory cultures and animal inoculations for the various possible agents are to be obtained: (1) An adequate volume of material must be collected. (2) A portion of the specimen must be saved in the unfixed state for microbiologic study if this proves desirable. The surgeon is of major importance in this teamwork of diagnosis because he is the one who obtains the proper type and quantity of material for the pathologist to make the indicated studies. Since surgical specimens usually cannot be duplicated, it is of prime importance for both members of the team to know and apply these fundamental procedures in order that the patient may be properly treated.

The Heart Page

Gordon Walker, M.D. – Coeditors – Robert Singleton, M.D.

A SERVICE OF
THE HEART ASSOCIATION OF MARYLAND

Prognostic Guides in Acute Rheumatic Fever

W. GORDON WALKER, M.D.

The problem of predicting the long term outcome in patients with acute rheumatic fever with carditis has been a difficult one. During recent years much interest has centered about serologic studies in these patients which may be of help in following the acute attack. No laboratory test has been found to be of significant prognostic value. A recent report by Feinstein and DiMassa focuses attention on the importance of the clinical features of the initial attack in evaluating the prognosis.

These authors reported on the long term follow-up of 315 children and adolescents without previous heart disease and selected because their initial attack of rheumatic fever had not been followed by any recurrences during the period of follow-up. They were studied during the initial episode and followed monthly at the Irvington House Prophylaxis Study Clinic. All patients were followed for two years or more and over three-fourths had been followed for four years or more.

In searching for correlations between the clinical manifestations of the initial attack and long-term prognosis, these authors noted a striking relationship between the presence of valvulitis during the initial episode of rheumatic fever and the subsequent long term manifestations of the disease. Valvulitis was diagnosed in those patients in whom a diastolic murmur was observed to appear or disappear during the acute illness. Those patients who developed loud apical systolic murmurs radiating to the axilla but no diastolic murmurs and those with a questionable diastolic murmur were labeled probable valvulitis. Of the 96 patients with valvulitis, two-thirds (63) had rheumatic heart disease at the time of the report. There were 52 patients classified as having probable valvulitis and of these approximately one-third (15) had rheumatic heart disease at the time of last follow-up. Diagnosis of rheumatic heart disease at follow-up was based upon the demonstration of the classic findings of stenosis or regurgitation of one or more of the heart valves.

Of equal interest were the follow-up findings on the 167 patients who had no valvulitis with the acute attack. Although such findings as cardiac enlargement, gallop rhythm, prolonged PR interval and other changes of carditis (exclusive of the murmurs listed above) were noted in these patients during their initial episode, *none* of these patients was observed to have any clinical findings suggestive of rheumatic heart disease at any time during the follow-up study.

The importance of these findings cannot be overemphasized, although they must certainly be regarded as preliminary in view of the average follow-up of only five years. Although previous studies have indicated that the severity of the carditis is of importance in determining the final outcome in this disease, this is the first study to call attention to the prime prognostic significance of the presence or absence of rheumatic valvulitis in the acute illness. If further follow-up confirms these findings, the authors will have increased our knowledge of the natural history of the isolated attack of rheumatic fever. They will also have provided us with a basis for evaluating the efficacy with which various therapeutic regimens, such as the steroids, alter the long term course of rheumatic fever.

It should be emphasized that these were all instances of a single attack of acute rheumatic fever but knowledge of the natural history of the isolated attack will provide a framework for obtaining information about the more complex course of repeated bouts of rheumatic activity in a given patient. This study also re-emphasizes the prime importance of careful clinical observation.

Department of Medicine
Johns Hopkins Hospital
Baltimore 5, Maryland

REFERENCE

FEINSTEIN, H. R. AND R. DIMASSA: Clinical Research **6**: 221, April 1958.

Blue Cross - Blue Shield

SERVICE BENEFITS

BY DENWOOD N. KELLY*

Maryland Blue Shield, from the beginning, has been a service rather than an indemnity plan. This is possible because of Blue Shield's three-way agreement under which members receive covered services in consideration of pre-paid membership fees, and Participating Physicians receive payment, which is stipulated, for services rendered to Blue Shield members. Participating Physicians, as part of their contribution toward the support of this Plan, agree to accept the Blue Shield benefit as full payment for covered services for those members whose incomes do not exceed stated limits.

In contrast, commercial insurance company contracts are two-way agreements between the company and the policyholder providing for the payment of stated cash indemnities. The doctor is not a party to this arrangement and has no voice in the preparation or modification of schedules of benefits, nor in the determination of medical policies.

From time to time physicians ask if participation in Blue Shield's service plan is advantageous to both the doctor and the subscriber. We feel that there is irrefutable evidence that it is.

William H. Horton, M.D., Executive Director of the Connecticut Blue Shield Plan, has made the following summary of the situation: "There are only three statements that need to be understood and accepted by any practicing physician in order for him to be willing to give his unqualified support to a Full Payment (service benefits) program. The first is that Full Payment is the only practical manner in which the tradition of the medical profession can be applied to the practical considerations of the business of running an insurance company. Second, Full Payment is primarily for the welfare of the patient whose interest medicine has always been proud to protect, and lastly, Full Payment is the only means by which medicine, in the long picture, can be maintained as a voluntary profession."

There are two obvious advantages of service benefits. For the patient under income limits, Blue Shield means full payment, not just a "down payment" as in the case of indemnity coverage when the doctor is free to charge any amount he wishes over the insurance coverage payment. For the Participating Physician there is the contractual assurance that his fee will be paid by Blue Shield to him. This is not true in the case of indemnity coverage when, the doctor not being a party to the agreement, payment is made to the patient who may dispose of it as he chooses.

In offering a service benefit program, it is absolutely necessary, from the standpoint of sound underwriting, that a representative cross section of the community be enrolled. If the program were made available only to the lowest income group, Blue Shield would retain all classes of risks in this group, but the good risks of the middle income group not eligible for service benefits would be unduly attracted to commercial competition. Since a higher proportion of good risks are in the middle income groups, it is necessary to make service benefits available to them also. Blue Shield can cover the low income, high cost elements of the population at an acceptable subscription rate only if it enrolls a substantial share of the higher income, lower cost elements. As the level of the national economy has risen and as health insurance plans have become more and more important in this economy, an increasingly large number of people want to have full coverage for the professional services which are covered under such prepayment plans. It is for precisely this reason that Maryland Blue Shield has developed two levels of coverage, Plan A and Plan B, in its total program.

This idea of service benefits—a really dependable benefit to the patient combined with assurance of payment to the doctor—is one of three exclusive hallmarks of Blue Shield. Service to the community and the preservation of the private, confidential relationship between the doctor and his patient are the other two and, combined with the first, form the bulwark of our voluntary plan of medical care prepayment in America.

* Assistant Director, Maryland Medical Service, Inc.

Health Departments

BALTIMORE CITY HEALTH DEPARTMENT

City Health And Mental Hygiene

Two dates—May 28 and June 26, 1958—saw the Baltimore City Health Department well advanced into the general field of mental hygiene, a health problem with which it had concerned itself in a preliminary manner for over a decade.

In his May 30 *Saturday Letter to the Mayor* the Commissioner of Health described the first meeting as follows:

"You will be pleased to learn that last Wednesday, May 28, the Baltimore City Health Department and the Baltimore Council of Social Agencies jointly sponsored the First Conference on the Mental Hygiene Resources and Needs of Baltimore City.

"The meeting (an all day session) was held in my office and twenty-five persons, representing official and nonofficial agencies with active interests in mental hygiene work, were present. These conference participants were concerned chiefly with exploring the following matters: (1). What is the scope and volume of work in mental hygiene presently administered in Baltimore City? (2). By which agencies is this work administered? (3). What are the principal unmet mental hygiene needs of Baltimore City residents at this time? (4). Who could reasonably be expected to consider furnishing needed services or some part thereof?

"Dr. Paul V. Lemkau of the Johns Hopkins School of Hygiene and Public Health made an opening statement on the goal of the Conference which was in general the development of a comprehensive program of preventive and therapeutic mental hygiene services for Baltimore.

"Discussions during the day left no doubt in the minds of those present that much mental hygiene work was being done in Baltimore, and that there are two basic mental hygiene needs in the city: first, a need for additional diagnostic and treatment clinic services for emotionally disturbed children; and, second, a need for selecting some agency to integrate the several mental hygiene programs in the city. Further discussion of the four areas of study mentioned above will be continued at the Second Conference.

"The names of those who attended the First Conference and the organizations they represented are as follows: Mr. Robert S. Hoyt, Director of Lutheran Hospital, who was asked to serve as chairman of the meeting; Miss Barbara J. Ashenden, Instructor in Psychiatry at the Harriet Lane Home; Dr. Charles Bagley, III, Psychiatrist at the University of Maryland School of Medicine; Mr. Charles L. Benton, City Budget Director; Mrs. Henrietta DeWitt, Director of Social Services at the Maryland State Department of Mental Hygiene; Very Reverend Monsignor David I. Dorsch, Director of the Associated Catholic Charities; Mr. Milton Goldman, Executive Director of the Jewish Family and Children's Bureau; Mr. Clark S. Hobbs, Chairman of the Division of Medical and Health Agencies of the Baltimore Council of Social Agencies; Mrs. Frank Jones of the League of Women Voters of Baltimore; Dr. Paul V. Lemkau, Professor of Public Health Administration at the Johns Hopkins School of Hygiene and Public Health; Dr. Arthur Lichtenstein, Director of Special Services in the Baltimore City Department of Education; Mr. William A. Martin, Secretary of the Division of Medical and Health Agencies of the Baltimore Council of Social Agencies; The Very Reverend Doctor Leo J. McCormick, Superintendent of Catholic Schools Administration; Miss Elaine Michelson, Executive Director of the Metropolitan Baltimore Association for Mental Health; Mr. Clark L. Mock, Executive Secretary of the Family and Children's Society; Mr. John F. O'Grady, Director of Juvenile Probation in the Circuit Court of Baltimore City; Mrs. John B. Ramsey, Jr., President of the Metropolitan Baltimore Association for Mental Health; Dr. Harrie M. Selznick of the Baltimore Council of Social Agencies; Dr. Robert E. Thomas, Chief of the Division of Mental Health of the Maryland State Department of Health; and Dr. Eberhard H. Ulenhuth, Psychiatrist at the Johns Hopkins Hospital.

"City Health Department members who attended were: Dr. Matthew L. Tayback, Assistant Com-

(Continued on page 456)

STATE OF MARYLAND DEPARTMENT OF HEALTH

MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, June 20–July 17, 1958

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT. AND SERUM	MEASLES	MENINGOCOCCAL INFECTIONS	MUMPS	POLIOMYELITIS, PARALYTIC	POLIOMYELITIS, NON-PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS: Influenza and pneumonia
Total, 4 weeks																		
Local areas																		
Baltimore County	11	—	25	—	35	1	7	—	—	—	—	—	—	8	—	5	e-1 m-1	3
Anne Arundel	1	—	—	—	—	—	—	—	—	—	1	—	—	5	—	7	—	2
Howard	—	—	—	—	—	—	—	—	—	—	1	—	—	2	—	—	—	—
Harford	—	—	2	—	5	—	—	—	—	—	—	—	—	2	—	3	—	1
Carroll	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	11
Frederick	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	1	—	1
Washington	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—
Allegany	—	—	—	—	12	—	—	—	—	—	1	—	—	2	—	1	m-1	—
Garrett	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Montgomery	6	—	16	5	35	—	—	—	—	—	7	—	1	5	—	4	m-1 e-1	2
Prince George's	1	—	4	—	28	2	—	—	—	—	9	—	—	14	—	21	m-4	4
Calvert	—	—	—	—	—	—	—	—	—	1	—	—	—	—	1	—	—	—
Charles	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—	—	1
Saint Mary's	—	—	—	—	—	—	—	—	—	4	—	—	—	—	—	—	—	1
Cecil	—	—	—	1	4	—	1	—	—	—	—	—	—	—	—	—	—	—
Kent	2	—	—	—	—	—	—	—	—	—	—	—	—	2	—	1	—	—
Queen Anne's	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Caroline	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—
Talbot	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	5	m-1	1
Dorchester	—	—	—	1	—	—	—	—	—	—	—	—	—	3	—	—	e-1	—
Wicomico	—	—	2	3	11	—	4	—	—	—	—	—	—	—	—	9	e-2	—
Worcester	1	—	—	—	1	—	—	—	—	—	—	—	—	2	—	—	—	—
Somerset	—	—	—	—	—	—	—	—	—	—	—	—	—	2	1c	—	—	—
Total, Counties	22	0	49	10	131	3	12	0	0	6	19	0	1	53	4*	58*		27
Baltimore City	103	0	61	4	95	2	19	0	0	0	12	0	2	59	16	593		17
State																		
June 20–July 17, 1958	125	0	110	14	226	5	31	0	0	6	31	0	3	112	20	651		44
Same period 1957	90	0	21	6	181	4	116	0	0	5	25	1	42	113	26	548		39
5-year median	102	1	32	31	300	2	180	9		8	36	2	43	160	20	645		26
Cumulative totals																		
State																		
Year 1958 to date	1412	3	2123	67	1644	18	368	0	0	9	443	3	47	905	139	3850		582
Same period 1957	1868	1	226	80	951	21	1843	4	0	9	728	2	195	948	129	3762		398
5-year median	2987	8	516	195	4133	30	1934	15		14	1217	10	217	1172	132	4035		456

e = encephalitis.
m = meningitis, other than meningococcal.
* = total includes cases reported by State Institutions. c = Migrant Labor Case.

Woman's Auxiliary Medical and Chirurgical Faculty

MRS. DAVID S. CLAYMAN, *Auxiliary Editor*

COMPONENT AUXILIARIES COMING EVENTS

Many festivities are being planned for early fall by our component auxiliaries. Among them are:

Baltimore City Auxiliary—sponsoring a "Red Shoes" dinner dance on September 27th at the Southern Hotel. This is to be held to raise funds for this auxiliary's charities. Everyone is invited to attend. Contact Mrs. Robert C. Kimberly for tickets and further information.

Baltimore County—Plans to have a luncheon and card party at noon on October 30th at the Green Spring Inn. This is for the benefit of A.M.E.F. All are, of course, welcome, and Mrs. Thomas Wheeler is the person to contact for further information.

FUTURE NURSES

There was a meeting of the Future Nurses of Maryland in July. Among those attending were representatives from the Maryland League for Nursing; the 1957–58 and 1958–59 officers of Future Nurses of Maryland; Mrs. E. Roderick Shipley, President of the Medical and Chirurgical Faculty Auxiliary; Mrs. D. Delmas Caples, President-Elect of the Medical and Chirurgical Faculty Auxiliary; and all the Component Chairmen of Recruitment.

AUXILIARY WORKSHOP

August 19—Greenspring Inn—Dutch Treat Luncheon. State Board Meeting at 10:30 a.m. followed by Dutch Treat Luncheon, then "Workshop" for all component auxiliary officers and chairmen.

OCEAN CITY MEETING—SEPTEMBER 12

The Woman's Auxiliary will meet in Ocean City at the same time the Medical Society holds its Semi-Annual Meeting. Mrs. E. Roderick Shipley, President, invites all the wives to attend.

The meeting will begin at 10 a.m. at the Commander Hotel in the social room. Coffee and buns will be served.

Library Additions

(*Continued from page 378, July 1958*)

Tuberculosis in white and negro children, v. 1 by J. B. Hardy; v. 2 by M. E. Bailey, 1958

Walsh, F. B., Clinical neuro-ophthalmology, 1957

Wechsler, I. S., Clinical neurology, 1958

Whitby, Sir, L. E., Disorders of the blood, 1957

White, P. D., Cardiovascular rehabilitation, 1957

Wilkins, Lawson, Diagnosis and treatment of endocrine disorders, 1957

Wolman, I. J., Laboratory applications in clinical pediatrics, 1957

Woods, N. B., The healings of the Bible, 1958

Zinsser, Hans, Bacteriology, 1957

Health Departments

(*Continued from page 454*)

missioner of Health for Research and Planning; Dr. Allan Goldfarb, Director of the Division of Mental Hygiene Research; Mr. Joseph Gordon and Mr. James Oswald of the Bureau of Health Information; and the Commissioner of Health."

The second meeting, on June 26, participated in by the same persons and agencies concerned itself primarily with the following matters: (1). Recommendation for an appropriate agency or committee for coordinating the community mental hygiene activities in Baltimore City. (2). Description of the proposed City Health Department Bureau of Mental Hygiene.

Huntington Williams, M.D.

Commissioner of Health

Book Reviews*

Surgery in Infancy and Childhood, Matthew White and Wallace M. Dennison; published by E. & S. Livingstone, Ltd., Edinburgh and London. Williams and Wilkins, Baltimore.

This book is designed to introduce to the senior student some of the surgical problems encountered in infancy and childhood. It is not a book of reference for the pediatric surgeon; it is not complete and in the preface states so. In many ways it is unbalanced. The teaching is based on the authors' experience in the Royal Hospital for Sick Children, Glasgow.

Clinical Enzymology, Gustav J. Martin, Sc.D., Little, Brown & Co., Boston, Mass. This book discusses a new field of medicine, the parenteral administration of enzymes, their systemic actions and their therapeutic effects. It is divided into sections designed to familiarize the reader with the actual clinical data available and to provide an insight into what is known about mechanisms of action and rationale underlying the use of biological catalysts in therapy.

Textbook of Medical Treatment, D. M. Dunlop, Sir Stanley Davidson, S. Alstead, E. & S. Livingstone, Ltd., Edinburgh and London; Williams and Wilkins, Baltimore, Md.

This is the seventh edition of this book, the sixth edition being published four years ago. Three new chapters have been added dealing with Corticotrophin and Cortisone, Anticoagulant Therapy and Principles of Prescribing. This is a handy reference book for the beginning physician, as well as for those long in practice.

How to Live with Diabetes, Henry Dolger, M.D., and Bernard Seeman. W. W. Norton & Company, Inc., 55 Fifth Avenue, New York 3, N. Y.

This is a book for diabetics and for those relatives and friends who are concerned with the disease. Its major emphasis is on the person with diabetes rather than on the ailment or condition. While it covers questions of diagnosis and treatment, it is primarily concerned with the human factors, the problems of daily living as they relate to growing up, work, marriage, sex, aging and the means of adjusting to the numerous physical and emotional demands of the disease.

* The reviews here published have been prepared by competent authorities and do not represent the opinions of any official bodies unless specifically stated.

CIRCLE

THE DATE

NOW!!

FRIDAY,

SEPTEMBER 12

SEMI-ANNUAL

MEETING

OCEAN CITY

JOIN THE FUN

IN THE SUN

Ocean City

FRIDAY, SEPTEMBER 12, 1958

SEMI-ANNUAL MEETING

MEDICAL AND CHIRURGICAL

FACULTY

Your Invitation to the Semiannual Meeting of the

MEDICAL AND CHIRURGICAL FACULTY

FRIDAY, SEPTEMBER 12, 1958—OCEAN CITY, MARYLAND

The Committee on Scientific Work and Arrangements has planned another interesting and entertaining meeting for Friday, September 12, 1958, at the Commander Hotel in Ocean City.

HEADQUARTERS—COMMANDER HOTEL

BUSINESS SESSIONS

COUNCIL.....Thursday, September 11, 8:00 P.M.
HOUSE OF DELEGATES.....Friday, September 12, 9:30 A.M.

SCIENTIFIC and SOCIAL PROGRAM—FRIDAY, SEPTEMBER 12

SCIENTIFIC SESSION.....12:30 P.M.
Recognition and Treatment of Anemia. **C. Lockard Conley, M.D.,** Professor of Medicine, The Johns Hopkins University School of Medicine, Baltimore.
CLAM BAKE.....2:30 P.M.
DANCE.....9:30 P.M.

Make your plans now to attend the Semiannual Meeting with your family and enjoy the attractive social functions and informative scientific meeting. Members are invited to attend the meeting of the House of Delegates.

FOR DETAILS SEE PAGE 399